Oregon All Payer All Claims (APAC) Program

Application for Limited Data Files

APAC-3

This application is used to request limited data sets. If you would like to discuss APAC data in relation to your project prior to submitting this application, please contact apac.admin@odhsoha.oregon.gov with a brief description of the project and your contact information. OHA will have someone contact you to help determine if APAC is appropriate for your project and, if so, which data elements may be needed.

PROJECT INFORMATION

Project Title: The Impact of Reinsurance on Insurer Behavior and Moral Hazard

Principal Investigator: Maura Coughlin

Title of Principal Investigator: Assistant Professor of Economics

Organization: Rice University

Address: 6100 Main St, MS-22

City: Houston State: TX Zip Code: 77005

Telephone: 8474043697

Email: maura.coughlin@rice.edu

SECTION 1: PROJECT SUMMARY

1.1 Project Purpose: Briefly describe the purpose of the project. You may submit a separate document that details the project's background, methodology and analytic plan in support of your request for APAC data elements.

Our project focuses on studying the impact of reinsurance on insurers' behavior, such as their willingness to take on more risks and how they handle claims. We want to examine if and how insurance companies change their conduct when they believe another party will bear potential larger costs. We call this "insurer moral hazard," similar to the well-known moral hazard among those who bought an insurance policy. Moral hazard is when people take more risks because they are protected against the consequences. While this type of moral hazard has been studied before, looking at how insurance companies behave differently with reinsurance is a new area of research.

Please see attached document for a more detailed discussion.

1.2 Research Questions: What are the project's key research questions or hypotheses? If this project is research and has been approved by an Institutional Review Board (IRB), the research questions must align with the IRB approval documentation. If needed, a more detailed response may be submitted as a separate file.

- Note: APAC staff will use your response to this question to determine the minimum data elements necessary for this project, in accordance with the HIPAA minimum necessary standard. The research questions should be specific enough to justify the need for each data element beyond identifying it as a "potential confounding variable."

Please see attached project summary document. Our analyses focus primarily on measuring the impact of public reinsurance on insurer claims processing behavior, what we call "insurer moral hazard." As such, we ask how the distribution of claim denials and other processing decisions change or not at the boundary points of public reinsurance, since at those points the insurer bears less or more of the financial risk with a marginal claim. To do so, we must carefully track individual level claims costs for the insurer and account for what, aside from reinsurance, would be expected to influence claims processing decisions and insurer existing expectations of costs. We hypothesize that at the point where an additional claim moves the cumulative spend into the region of reinsurance coverage an insurer bears less financial risk and is thus may be more likely to approve (or otherwise ease) a claim. Similarly, as cumulative spend approaches the end of the range of reinsurance coverage an additional claim includes greater financial cost for the insurer as they no longer have reinsurance coverage. We hypothesize denial may be more likely.

1.3 Products or Reports: Describe the intended product or report that will be derived from the requested data and how this product will be used. If needed, a more detailed response may be submitted as a separate document with this application.

We intend to write 1-2 academic papers based on our analyses. As is custom in our profession, we plan to present our research results in academic conferences. Our timeline below reflects that economics, as a profession, has a fairly slow publication timeline. We anticipate completing our analyses sooner but want to include time for revisions.

1.4 Project Timeline: What is the timeline for the project?

Anticipated Start Date: 09/01/2024

Anticipated Publication/Product Release Date: 06/01/2027

Anticipated End Date: 09/01/2027

1.5 Data files may not be released or reused beyond the terms of the data use agreement resulting from this application regardless of funding source or other obligations of the principal investigator, organization or research team.

☒ I understand this limitation and agree that data files or work products will not be shared at less than an aggregated, de-identified level.

☐ I understand this limitation and request approval to share data files or work products at a potentially re-identifiable level as follows:

SECTION 2: PROJECT STAFF

2.1 Project Staff: Please list all individuals in addition to the principal investigator who will have direct or indirect access to the data. This must include any contractors or other third parties with access to the data.

Name: Maura Coughlin Email: maura.coughlin@rice.edu	Project role: Principal Investigator
Name: Salpy Kanimian Email: smk17@rice.edu	Project role: Researcher
Name: Email:	Project role:
Name: Email:	Project role:
Name: Email:	Project role:
Name: Email:	Project role:
Name: Email:	Project role:

Attach additional sheets as needed.

2.2 Technical Staff: Please list any additional staff who will be maintaining the data file(s) or otherwise assisting in the transfer or receipt of the data files. Files will not be transferred to anyone who is not listed on this application as either project staff or technical staff.

Name: Maura Coughlin Email: maura.coughlin@rice.edu	Technical role: Principal Investigator
Name: Email:	Technical role:

Attach additional sheets as needed.

SECTION 3: DATA REQUEST

3.1 Purpose of the Data Request:

a. Listed below are the purposes for which OHA may share APAC data. Please choose the category in which your project falls under (***choose only one***).

- [■] Research (refer to 45 CFR 164.501 for definition)
- [ ] Public health activities as defined in 45 CFR 164.512(b) by the state or local public health authority
- [ ] Health care operations as defined in 45 CFR 164.501
  - Covered entity as defined in 45 CFR 160.103? [ ] Yes [ ] No
- [ ] Treatment of patient by health care provider as defined in 45 CFR 164.506 (c)(2)
  - Covered entity? [ ] Yes [ ] No
- [ ] Payment activities performed by covered entity or health care provider as defined in 45 CFR 164.506 (c)(3)
  - Covered entity? [ ] Yes [ ] No
- [ ] Work done on OHA's behalf by a Business Associate as defined in 45 CFR 160.103

b. Describe how the project falls into the category chosen above.

The project is academic research by a University professor and graduate student with the aim of writing academic research papers for publication in economics and health journals.

3.2 Direct identifiers. What level of data identifiers are you requesting (***choose only one***)? Reference the Data Elements Workbook for the categorization of data elements.

- [ ] De-identified (as outlined in 45 CFR 164.514(e)) protected health information
- [■] Limited, potentially re-identifiable data elements
- [ ] Restricted direct identifiers (member name, address, date of birth, etc.) *Please note:* Direct identifiers are only released under special circumstances that comply with HIPAA requirements, and will require specific approvals, such as IRB approval, patient consent and/or review by the Oregon Department of Justice.

3.3 Human Subjects Research: IRB protocol and approval are required for most research requests for limited data elements. Not obtaining IRB approval or waiver in advance may delay approval of the data request. **The research questions reported in 1.2 of this application must match the documentation supporting the IRB approval received or the IRB approval will not be accepted for this data application.**

The IRB application should indicate that APAC data contains sensitive personal health information and is subject to HIPAA regulations.

a. Does the project have IRB approval for human subjects research or a finding that approval is not required?

☒ Yes ☐ No

If no, briefly explain why you believe that this project does not require IRB review.

If an IRB reviewed the project, include the IRB application and approval/finding memo with the submission of this APAC-3 and complete parts b-e below.

☑ IRB application and approval memo are attached.

b. Describe how this application is within the authority of the approving IRB.

Rice's Institutional Review Board (IRB) is the relevant authority for the researchers' work conducted at Rice University

c. Describe why the project could not be practicably conducted without a waiver of individual authorization (a waiver of individual authorization is provided by the IRB in cases in which the researcher does not need written authorization from participants to use their PHI):

This is a retrospective study of routinely collected data not involving participant recruitment and a large number of participants, consent is thus not practical.

d. On what date does the IRB approval expire? 06/01/2030

SECTION 4: DATA ELEMENTS

4.1 Narrowing Data Needs: Refer to the APAC Data Dictionary for detailed information about the data elements. In compliance with HIPAA regulations, you will only receive data elements that are adequately justified. This means APAC will only provide the minimum necessary data required for the project as represented in the research questions, protocol and IRB approval.

a. What years of data are requested? 2011 through 2022 are currently available.

2014-2022

b. What payer types are requested? Check all that apply

☑ Commercial ☐ Medicaid ☐ Medicare Advantage

c. What types of medical claims are requested? ☑ All

☐ Inpatient hospital ☐ Emergency department ☐ Outpatient
☐ Ambulatory surgery ☐ Ambulance ☐ Transportation
☐ Hospice ☐ Skilled Nursing Facility ☐ Professional

d. Demographic data limitations

1. Gender ■ All ☐ Male ☐ Female

2. Age ☐ All ☐ Only 65+ ☐ Only 18 and younger ■ Other 18-64
(Specify age range)

e. Will data requested be limited by diagnoses, procedures or type of pharmaceutical? Add additional sheet if needed.

Diagnoses, indicate ICD 9 and ICD10 codes to include:

No, all for ACA commercially insured individuals.

Procedures, indicate CPT to include:

Pharmaceuticals, indicate NDC or therapeutic classes to include:

f. APAC has a small number of out-of-state residents included, most often through PEBB or OEBB coverage. Do you want to include out-of-state residents? ☐ Yes ■ No

4.2 Data Element Workbook: Complete the Data Element Workbook to identify specific data requested.

Data Element Workbook completed and attached, including justifications for each element requested. ☑

SECTION 5: DATA MANAGEMENT & SECURITY

5.1 Data Reporting: APAC data or findings may not be disclosed in a way that can be used to re-identify an individual. Data with small numbers – defined as values of 30 or less (n≤30) or subpopulations of 50 or fewer individuals (n≤50) – cannot be displayed in findings or outputs derived from APAC data. Please describe the techniques you will use to prevent re-identification when findings or outputs result in small numbers or subgroups (e.g. aggregation, cell suppression, generalization, or perturbation).

We will adhere to all guidelines regarding the sensitivity of data and minimize risks to individuals. We will not report statistics for which there are small numbers of people. We will aggregate individuals as feasible and suppress when small numbers are unavoidable. We will make no attempts to reidentify or link with data that risks reidentification. Additionally, our analyses focus on the insurer and thus will not display detailed personal data

5.2 Data Linkage: OHA seeks to ensure that APAC data cannot be re-identified if it is linked or combined with data from other sources at the record, individual or address level. Requesters are strongly encouraged to consult with APAC staff regarding linking APAC data with other data prior to submitting a data request. Health Analytics prefers to conduct APAC data linking in-house and share only encrypted identifiers with data requesters.

a. Does this project require linking to another data source?

☐ Yes ■ No

If yes, please complete parts b-d below.

b. At what level will data be linked?

☐ Address ☐ Facility ☐ Individual person/member
☐ Individual provider

c. If required to link

☐ Authorized to provide data for linking at OHA
☐ Not authorized to provide data for linking at OHA
☐ Unknown

d. Describe and justify all necessary linkages, including the key fields in each data set, how they will be linked, the software proposed to perform the linkage and why it is necessary.

The only additional data our project requires is information about insurer private reinsurance activity from the National Association of Insurance Commissioners (NAIC). As such, we will not be linking individuals to other data sources, but we will be using additional information about the private reinsurance market to supplement what we know about insurance providers (payer_cd) operating in the Oregon marketplace.

e. Describe in detail the steps will you take to prevent re-identification of linked data.

We will not be linking individuals, only insurers, to additional data in order to measure total reinsurance activity by payers. Thus there is no risk of re-identification with regards to linked data.

5.3 Data Security (required for all applications):

a. Attach a detailed description of your plans to manage security of the APAC data including:
   - Designation of a single individual as the custodian of APAC data, either the principal investigator or staff listed in Section 2 of this application, who is responsible for oversight of APAC data, including reporting any breaches to OHA and ensuring the data are properly destroyed upon project completion.
   - A security risk management plan applicable to APAC data that includes:
     - Secure storage in any and all mediums (e.g., electronic or hard copy)
     - Procedures to restrict APAC data access to only those individuals listed on the data use agreement
     - User account controls, i.e., password protections, maximum failed login attempts, lockout periods after idle time, user audit logs, etc.
     - Confirmation of training for personnel on how to properly manage protected health information in all formats
     - Protection of derivatives of APAC data at the re-identifiable level
     - If applicable, procedures for handling direct identifiers, such as allowing access on a 'need to know' basis only and minimizing risk by storing identifiers separately from other APAC data
     - Procedures for identifying, reporting and remedying any data breach
   - Statement of compliance with HIPAA and the HITECH Act
   - Electronic device protections, i.e., anti-virus or anti-malware software, firewalls, and network encryption

b. Record level or derivative data that can be re-identified must be destroyed within 30 days of the end of the data use agreement, in a manner that renders it unusable, unreadable or indecipherable. What are your plans for destruction of the dataset and any potentially identifiable elements of the data once the data use agreement has expired?

Dr. Maura Coughlin will work with Rice University's Office of Information Technology. Destruction will be overseen by OIT at Rice University using NIST SP 800-88 R1 guidelines for Media Sanitization at the termination of the project.

SECTION 6: COST OF DATA

Because each data set is unique, cost can be determined only after the specific data elements are finalized. APAC staff will then review your request and estimate the number of hours required to produce and validate the data. APAC requires reimbursement for the cost of file transfer ($890 per request) and the total time spent by APAC staff on research and administrative activities. Payment must be received before the data will be provided. APAC staff will provide an invoice to facilitate payment. OHA's W-9 is available on request.

SECTION 7: CHECKLIST AND SIGNATURE

7.1 Checklist: Please indicate that the following are completed:

- ☒ I acknowledge that payment will not be refunded if OHA fulfills the data request, but the receiving entity does not have the capability to import or analyze the data
- ☒ All questions are answered completely
- ☒ Data Element Workbook is attached to email or printed application
- ☒ IRB application with approval/finding memo is attached to email or printed application, if applicable
- ☒ Data privacy and security policies for the requesting organization, and any third-party organizations, are attached to the email or printed application

7.2 Optional Racial Justice Addendum: Please see the last two pages of this form for options if data will be used to eliminate racial injustice.

- ☐ I am interested in this option
- ☒ This option does not apply to my data request

7.3 Signature: The individual signing below has the authority to complete this application and sign on behalf of the organization identified in Section 1. By signing below, the individual attests that all information contained within this data Request Application is true and correct.

Signature

Date 08/13/2024

Printed name Maura Coughlin

Title Assistant Professor of Economics

Return the completed form with required attachments to APAC.Admin@odhsoha.oregon.gov.

Optional APAC Addendum: Using APAC Data to Eliminate Racial Injustice

Requestors may complete this optional section if their project will identify concrete actions to eliminate health inequities stemming from historical and contemporary injustices and the inequitable distribution of resources and power (see Health Equity definition on next page). For projects that inform such solutions, and **do not simply document disparities**, the Director of the **Office of Health Analytics** may, at their discretion, offer one or more of the following incentives:

- Priority processing of requestor's application
- Waiver of fees
- Priority production of data files
- Technical assistance from APAC analysts
- Access to enhanced race and ethnicity data in the future. (Race/ethnicity data in APAC are currently limited because entities that submit administrative data to APAC do not generally include race/ethnicity information.)
- Other provisions that the Director of Health Analytics may find appropriate

Receipt of any of these incentives requires requesters to deliver to the Office of Health Analytics a document fully describing the analytic methods at the conclusion of the relevant analyses, including:

- Commercial off-the-shelf applications used
- Grouping and aggregation methods
- Algorithms and calculations
- Use of code sets that are proprietary to a third party not associated with the project
- Copies of programming code attached in an appendix

The Office of Health Analytics will compile a compendium of analytic methods and make this freely available on the APAC web site. Requestors are also encouraged to submit copies of publications or products using the APAC data for posting on the APAC web site. See below for additional information and application instructions.

Using APAC Data to Eliminate Health Inequities

Problem: Health inequities due to institutional racism and racial injustice

Solution: Develop methods for using APAC data to eliminate institutional racism and racial injustice.

Goal: Eliminate institutional racism and racial injustice, including discrimination based on the intersections of race, ethnicity, language and disability.

Rationale: OHA recognizes that historical and contemporary racial injustice is a root cause of health inequity. APAC and its users, who have subject matter expertise, infrastructure, and staffing sufficient to use the large and complex data files, comprise a community of privilege. As such, APAC has an obligation to use its privilege to confront institutional racism and racial injustice, within OHA specifically and across Oregon. The APAC community has a tremendous wealth of research expertise that could develop novel methods for using APAC data to document racial injustice and identify opportunities to eliminate it.

Instructions: In a separate attachment, describe in detail:

- How requestor's research will help requestor's organization and OHA document racial injustice **and** identify opportunities to eliminate it. Requestor's description must be thorough and as specific as possible and should describe how the research findings will be consistent with OHA's efforts to achieve true Health Equity (see definition, below). **Simply documenting disparities is not sufficient**.
- How requestor's research will be explicitly clear and open about the methods used, widely replicable, and not proprietary to requestor's organization or to a third party. Note that this does not preclude requestor's use of necessary codes sets, such as CPT codes, that are proprietary to a third party and available for license.
- How requestor's organization will freely share the key findings.

A note on intersectional research into inequities based on race, ethnicity, language and disability: Researchers are encouraged to consider an intersectional approach that encompasses language and disability when researching strategies to eliminate racism and racial injustice. However, administrative claims data submitted to APAC generally do not include data on language or disability. APAC includes some race and ethnicity data, but it encompasses less than half of the people in the database. To mitigate these limitations, OHA staff may be able to provide assistance to selected applicants interested in intersectional approaches, as staff resources permit.

Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Project Summary: Maura Coughlin, Rice University

- Brief description of the proposed project in lay terms:

Reinsurance, also known as insurance for insurance companies, is an essential element of health insurance markets. It acts as a safety net, shielding insurers from huge unexpected costs by shifting some risk to another company. Reinsurance helps insurance companies keep their finances steady but can also influence how they operate in the market. With the added protection from reinsurance, insurers might change their approach to fulfill their obligations to policyholders.

Insurance firms can (and do) purchase reinsurance in the private market, but in the early years of the ACA marketplaces the Federal government established a reinsurance program for market participants. Under this program, for individual whose claims cost exceed the "attachment point" value, coinsurance covered a specified fraction of the costs to the insurers until the "reinsurance cap." At that point all costs revert back to the insurer.

Year	Attachment Point	Reinsurance Cap	Coinsurance	Notes	
2014	$45,000	$250,000	**100%**	Initially coinsurance set at 80%	**Federal Reinsurance**
2015	$45,000	$250,000	**55.10%**	Initially coinsurance set at 50%	
2016	$90,000	$250,000	50%		
2017					
2018	$95,000	$1M	**59.20%**	Initially coinsurance set at 50%	**State Reinsurance**
2019	$90,000	$1M	50%		
2020	$90,000	$1M	50%		
2021	$83,000	$1M	50%		
2022	$92,000	$1M	50%		
2023	$95,000	$1M	50%		
Federal reinsurance parameters: https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/					
Oregon reinsurance parameters: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5017					

Our project focuses on studying the impact of reinsurance on insurers' behavior, such as their willingness to take on more risks and how they handle claims. We want to examine if and how insurance companies change their conduct when they believe another party will bear potential larger costs. We call this "insurer moral hazard," similar to the well-known moral hazard among those who bought an insurance policy. Moral hazard is when people take more risks because they are protected against the consequences. While this type of moral hazard has been studied before, looking at how insurance companies behave differently with reinsurance is a new area of research.

- Data description:

We propose using the Oregon All-Payer All Claims Database (APAC). Oregon APAC data includes de-identified patient-specific medical, and pharmacy claims across different insurance segments in Oregon. The data has been maintained and collected by the state since January 2010.

APAC data allows us to measure a patient's total claim experience in a given coverage year under the different reinsurance designs and the payment and denial outcomes of individual claims. Our project will focus on one segment of insurance, the individual health insurance market (commonly known as ACA or Obamacare plans), and during the years 2014-2022, which provides insurance to a relatively small population in Oregon.

- Methods:

Our project uses two methods to understand how reinsurance affects insurance companies' behavior.

First, we will do a descriptive analysis by looking at historical claims data, industry reports, and regulatory filings to infer how reinsurance has influenced insurance companies' risk management. That is, we will check how often claims get denied across patient cumulative and total costs, controlling for the details one would expect to impact denial rates irrespective of reinsurance. Descriptive analysis will thus help us identify behavioral patterns and trends over time. This analysis will use the following framework:

$$y_{cit} = \beta Reinsurance_t + \gamma X_c + \delta X_i + \nu_i + \mu_t + \epsilon_{it}$$

Where c indexes the claim, i insurance firm, t year, y is the outcome of interest (frequency of claim denials, preauthorization, timeliness of claim handling, ...), X s are vector of control variables that includes claim level information such as nature of claim (inpatient, emergency, outpatient..), diagnosis code, procedure/service code, whether service is received in network or out of network..., as well as insurer level, such as the whether the insurance firm has private

reinsurance, $Reinsurance$ is an indictor variable equal to 1 if public reinsurance subsidy is available in the market. The β coefficient is the estimate of the impact of presence of reinsurance on various aspects of insurer behavior. ν and μ are insurer and year fixed effects and ϵ stands for the error term independent of all fixed effects specified in the equation.

In tandem, we will use robust techniques to test whether the distribution of claim denials exhibits any excess or diminished mass around the critical parameters of reinsurance that mark crucial transitions within the reinsurance arrangement. We will use this strategy to test for two hypotheses. First, a profit-maximizing insurer knows that for claims exceeding the maximum reinsurance limit, they are no longer covered and are thus more likely to deny a claim. Second, an insurer is less likely to deny a claim at claims near the point where the reinsurance starts covering the expenses. These subtle changes in behavior can inform us if insurance companies are adjusting their strategies because of reinsurance. We will conduct similar analyses on other measures of claim processing ease, such as appealed and resubmitted claims. The approach taken in this strategy is to first graph the means of outcomes by the dollar value of the claim from the two cutoffs (separately) we are interested in. We will then estimate the size of the discontinuities (within-year and insurer) and assess their statistical significance, with a methodology similar to the following equation:

$$y_c = \gamma X_c + \beta\, cutoff_c + \nu_c$$

Where c indexes the claim, y is the outcome (as described above), X is a vector of control variables (as described above), and $cutoff$ is an indicator variable equal to 1 is the claim dollar value passed the relevant threshold.

After assessing whether firms strategically respond to the reinsurance programs, subsequent analyses depend on the initial findings. If insurers do appear to react through claim denial, we will further quantify the impact of this behavior on both insurer and patient costs. Lastly, we will assess the credibility of our findings and consider how to mitigate the moral hazard problem.

- Outcomes:

Our first-order outcomes of interest are insurer behavioral responses, such as claim denials and timely and effective processing of appealed and resubmitted claims. These outcomes are associated with our goal of examining how insurers change their behavior because of reinsurance and how this might affect patients and the healthcare system.

Examining claim denials will allow us to infer whether insurance companies are more likely to deny claims when they know reinsurance will no longer cover them or if they are more lenient when they know reinsurance will kick in soon.

When an insurance company denies a claim, the patient or healthcare provider might ask them to reconsider. By checking whether appeals and resubmitted claims are handled timely and effectively, we want to infer if reinsurance exhibits any moral hazard on the insurers' end.

AS INCLUDED IN IRB APPLICATION:

Research Description

Reinsurance, or insurance for insurance companies, is an essential element of health insurance markets. It protects insurers from unexpected costs by offloading some risk. With the added protection from reinsurance, insurers might change their approach to fulfill their obligations to policyholders. Our project focuses on studying the impact of reinsurance on insurers' behavior, such as their willingness to take on more risks and how they handle claims. We want to examine if and how insurance companies change their conduct when they believe another party will bear potential larger costs. We call this "insurer moral hazard," similar to the well-known moral hazard among those who carry an insurance policy. Moral hazard is when people take more risks because they are protected, to some extent, against the full financial consequences.

We propose using the Oregon All-Payer Claims Database (APCD), specifically the adult population age 18-64 who are enrolled in an individual health insurance plan through the ACA marketplace. Oregon APCD data includes de-identified patient-specific medical, dental, and pharmacy claims across different insurance segments in Oregon. APCD data allows us to measure a patient’s total claim experience in a given coverage year under the different public reinsurance designs and the payment and denial outcomes of individual claims. These data are secondary data, collected by statute in Oregon, and will not contain identifying information such as names or dates of birth. Our analyses will focus on the response of insurers, and thus all individual data used in analysis will be aggregated prior to final results. Risk to identifying the recorded individuals is minimal, both due to the lack of identifying information in the data as well as data management precautions taken in the study, such as aggregating across large numbers of individuals and cell suppression in instances where aggregation is infeasible.

Our first-order outcomes of interest are insurer behavioral responses, such as claim denials, prior authorizations, and timely and effective processing of appealed and resubmitted claims. First, we will do a descriptive analysis by looking at historical claims data, industry reports, and regulatory filings to infer how reinsurance has influenced insurance companies' risk management. That is, we will check how often claims get denied across patient cumulative and total costs, controlling for the details one would expect to impact denial rates irrespective of reinsurance. In tandem, we will use robust techniques to test whether the distribution of claim denials exhibits any excess or diminished mass around the critical parameters of reinsurance that mark crucial transitions within the reinsurance arrangement. We will use this strategy to test for two hypotheses. First, a profit-maximizing insurer knows that for claims exceeding the maximum reinsurance limit, they are no longer covered and are thus more likely to deny or otherwise obstruct a claim. Second, an insurer is

less likely to deny a claim at claims near the point where the reinsurance starts covering the expenses. We will then estimate the size of the discontinuities (within-year and insurer) and assess their statistical significance.

RICE UNIVERSITY
Office of Research Integrity
Institutional Review Board (IRB)

Jun 25, 2024 3:30:18 PM CDT

To: Maura Coughlin, Salpy Kanimian
From: Rice University Institutional Review Board
Study#: IRB-FY2024-406
Study Title: The Impact of Reinsurance on Insurer Behavior and Moral Hazard
Submission Type: Initial
Decision Date: June 25, 2024
Expiration Date: --

Dear Maura Coughlin:

The Rice University Institutional Review Board has rendered the decision below for The Impact of Reinsurance on Insurer Behavior and Moral Hazard.

Findings: Secondary Data Analysis: Researchers have no access to identifiers.

Decision: No Human Subjects Research

If you have any questions, please do not hesitate to contact the Compliance Administrator at 713-348-3586 or IRB@rice.edu.

Sincerely,
Christopher Fagundes, Ph.D., Chair
Rice University Institutional Review Board

Date: 8-13-2024

IRB #: IRB-FY2024-406
Title: The Impact of Reinsurance on Insurer Behavior and Moral Hazard
Creation Date: 6-3-2024
End Date:
Status: Approved
Principal Investigator: Maura Coughlin
Review Board: Institutional Review Board
Sponsor:

Study History

Submission Type Initial	Review Type Exempt	Decision No Human Subjects Research

Key Study Contacts

Member Maura Coughlin	Role Principal Investigator	Contact mc130@rice.edu
Member Maura Coughlin	Role Primary Contact	Contact mc130@rice.edu
Member Salpy Kanimian	Role Co-Principal Investigator	Contact smk17@rice.edu

Initial Submission

Research Description

Please insert a brief, but complete, description of your research (500 words or less). This should include the activities that will be involved, the question being investigated, a statement of whether the risk is minimal or greater, and identification of the study population.

If your Informed Consent document includes a Concise and Focused Presentation (see the template provided by the IRB), you may paste it here to fulfill this requirement.

If you believe that your project may qualify as Not Human Subjects Research, you may stop here and request an evaluation from an IRB Administrator at irb@rice.edu.

Reinsurance, or insurance for insurance companies, is an essential element of health insurance markets. It protects insurers from unexpected costs by offloading some risk. With the added protection from reinsurance, insurers might change their approach to fulfill their obligations to policyholders. Our project focuses on studying the impact of reinsurance on insurers' behavior, such as their willingness to take on more risks and how they handle claims. We want to examine if and how insurance companies change their conduct when they believe another party will bear potential larger costs. We call this "insurer moral hazard," similar to the well-known moral hazard among those who carry an insurance policy. Moral hazard is when people take more risks because they are protected, to some extent, against the full financial consequences.

We propose using the Oregon All-Payer Claims Database (APCD), specifically the adult population age 18-64 who are enrolled in an individual health insurance plan through the ACA marketplace. Oregon APCD data includes de-identified patient-specific medical, dental, and pharmacy claims across different insurance segments in Oregon. APCD data allows us to measure a patient's total claim experience in a given coverage year under the different public reinsurance designs and the payment and denial outcomes of individual claims. These data are secondary data, collected by statute in Oregon, and will not contain identifying information such as names or dates of birth. Our analyses will focus on the response of insurers, and thus all individual data used in analysis will be aggregated prior to final results. Risk to identifying the recorded individuals is minimal, both due to the lack of identifying information in the data as well as data management precautions taken in the study, such as aggregating across large numbers of individuals and cell suppression in instances where aggregation is infeasible.

Our first-order outcomes of interest are insurer behavioral responses, such as claim denials, prior authorizations, and timely and effective processing of appealed and resubmitted claims. First, we will do a descriptive analysis by looking at historical claims data, industry reports, and regulatory filings to infer how reinsurance has influenced insurance companies' risk management. That is, we will check how often claims get denied across patient cumulative and total costs, controlling for the details one would expect to impact denial rates irrespective of reinsurance. In tandem, we will use robust techniques to test whether the distribution of claim denials exhibits any excess or diminished mass around the critical parameters of

reinsurance that mark crucial transitions within the reinsurance arrangement. We will use this strategy to test for two hypotheses. First, a profit-maximizing insurer knows that for claims exceeding the maximum reinsurance limit, they are no longer covered and are thus more likely to deny or otherwise obstruct a claim. Second, an insurer is less likely to deny a claim at claims near the point where the reinsurance starts covering the expenses. We will then estimate the size of the discontinuities (within-year and insurer) and assess their statistical significance.

Personnel

*required

Principal Investigator

Please note that PI will generally be a faculty member at Rice University. The PI is required by University Policy 201 and 301 to have PI Eligibility. If you do not have PI eligibility, or if you do not know whether you have PI eligibility, you can contact an IRB Administrator for assistance.

Name: Maura Coughlin
Organization: Economics
Address: 6100 Main Street MS-22, Houston, TX 77005-1827
Phone:
Email: mc130@rice.edu

*required

Administrative Contact(s)

Please note that multiple Administrative Contacts are allowed.

Name: Maura Coughlin
Organization: Economics
Address: 6100 Main Street MS-22, Houston, TX 77005-1827
Phone:
Email: mc130@rice.edu

Co-Investigator(s)

Listing personnel in this section will provide them with access to the study protocol and documents. Generally, study personnel who are affiliated with Rice (i.e., students, staff, etc.) should be in this section.

Name: Salpy Kanimian
Organization: Economics
Address: 6100 Main Street MS22, Houston, TX 77005-1827

Phone:
Email: smk17@rice.edu

Non-Rice Affiliate Collaborator(s)

*Complete one copy of the Non-Rice Affiliated Study Member Form for each researcher who is **not** associated with Rice (faculty, staff, and/or students). Collaborators are required to complete appropriate training, and training certificates should be uploaded in the next section for each non-affiliated researcher.*

Training Certificate(s)

New! *It is no longer necessary to upload training certificates for research participants whose training originated through CITI and who are enrolled through Rice University. IRB Administrators can verify those researchers' training directly, so uploading these certificates is no longer required.*

Please contact an IRB Administrator if you are not sure which training is required for this study.

*Please upload all required training certifications for any **Non-Rice Affiliate Collaborators**. Please contact an IRB Administrator if you are not sure which research personnel require certificates to be uploaded.*

*required

Conflicts of Interest

Do any investigator(s) participating in this study have a financial interest related to this research project?

✓ No

Yes

Project Information

*required

Project Funding

The funding of human research projects plays an important role in research oversight practices. Please indicate the source of *any* funding for this research.

Federal Funding

Please indicate the funding agency and grant number.

Foundation/Private Funding

Please indicate the source of the funding.

✓ Funding from Rice University/Departmental Funding/Startup Funding

No funding

*required

Study Location(s)

Please indicate where the study activities will be performed (e.g., Rice University, another university, community centers, other countries, etc.).

Please note that "Zoom", "The Internet", etc. are not valid answers. In these cases, where will researchers and participants be located during these interactions.

Rice University

*required

Study Characteristics

Check each box that describes activity associated with the research that will be performed.

✓ Secondary Data Analysis

Interaction with Research Participants

Interventions Performed on Research Participants

Collection of Biospecimens from Research Participants

If this box is checked, Interventions must be checked as well.

Multisite IRB Research

Multisite IRB Research requires a reliance agreement. Please contact an IRB Administrator for assistance in arranging this agreement.

Community/Alternative Site Research

International Research Activity

Research Activities Involving Deception of Participants

Research that Qualifies as a Clinical Trial

A clinical trial is defined as

1. *A research study with one or more human subjects;*
2. *Subjects are prospectively assigned;*
3. *Subjects are assigned to one or more interventions (which may include placebos or other controls)*
4. *The effect of those interventions on health-related biomedical or behavioral outcomes.*

Investigation Using Devices Not Approved by the FDA

Secondary Research

Secondary research is the use of data or biospecimens that were collected outside of the research study under review. This can include materials collected for a different research study or materials collected for a non-research purpose (e.g., clinical or medical care).

Generally speaking, the IRB differentiates between the use of

- ***non-protected*** *secondary data or specimens (i.e., materials for which no identifying information exists or for which any identifying information is publicly available, such as data or samples commonly found in governmental databases or biobanks)*
- ***protected*** *secondary data or specimens (i.e., materials for which identifying information would be available to the researchers but not to the public).*

The IRB typically uses the HIPAA Safe Harbor standard to determine the presence or absence of identifiable information.

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*required

Secondary Materials Being Used

Publicly Available Secondary Materials

✓ Secondary Data

Description of Data

Describe the data you are obtaining. For example, if this is private human subjects data collected in another study, please describe the nature of the data.

Medical claims data collected by the state of Oregon for their All Payers All Claims database. Data is at the individual health claim level, and includes costs and diagnosis codes, but the data requested by researchers to be released from APAC do not include detailed information about the individual, such as name, address, date of birth (although will include age in years).

Source of Data

Please provide the origin of the data.

All payers within Oregon are required to submit all claims of individuals in Oregon to the state's all payers all claims database (Oregon APAC). It is through Oregon's APAC that the data is collected together and provided to researchers with an approved study, only after University IRB approval is obtained.

Identifiers

Indicate the identifiers, if any, on the data. If data are encoded, please indicate whether investigators will have access to the code reidentifying data.

Individuals will be linked across their claims by an individual id number, but researchers will not have access to any code reidentifying anyone from those id numbers. We are specifically not requesting further identifying information contained in the raw data, such as dates of birth.

Informed Consent

Were the data obtained under an IRB-approved Informed Consent? Did the original Informed Consent indicate that the data may be shared?

No, data is collected as an administrative dataset required by Oregon law rather than collected in a study.

Secondary Samples

Risk/Benefit Analysis

*required

Evaluation of Risk Level

Indicate the level of risk anticipated to research participants.

Minimal risk
*(The probability **and** magnitude of harm or discomfort anticipated in the research are not greater*
✓ *than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.)*

Greater than minimal risk

*required

Potential Risks/Discomforts to Participants

Please describe the potential risks and discomforts to research participants, including (but not limited to):

- loss of privacy (and the potential fallout from loss of privacy, including potential for loss of benefits to education, employment, or insurance, loss of social status)
- embarrassment
- stress
- potential discovery of information about genetic disorders or heredity
- bodily harm from interventions
- other foreseeable risks.

As we are proposing a study of a deidentified secondary administrative dataset of medical and pharmacy claims, risk to the individual is minimal but relates to the privacy risk of sensitive health information contained in claims, such as diagnoses and treatments. We will not request sufficient information to identify individuals, will make no attempt to identify individuals, and will not report results that are based on a small number of individuals, further mitigating the minimal risk. We are additionally not including in our data request any children or elderly individuals (we are only requesting adults 18-64 enrolled in an individual health insurance plan).

Duration of Risk

Please explain how long any potential harms may come to the participant may last.

Risks are minimal, but it is unknown how long potential emotional harm from loss of privacy would last. But again, we are not requesting data that makes the chances of identification more than extremely minimal.

*required

Potential Benefits

Please describe benefits that are anticipated to come from this research, both to individuals and to society as a whole.

*(Please note that research compensation is **not** the same as research benefits. Benefits are inextricable from the research being performed; i.e., benefits cannot be obtained without participating in the research being done. Please note that the IRB is not seeking a justification for your research project; the answer, "There are no known direct benefits to participants", is an acceptable answer.)*

Our proposed project will help researchers and society at large understand the consequences of public policy related to providing reinsurance to firms participating in the ACA marketplace (something policy makers want to encourage) on enrollees ability to use their plans easily (something policy makers are not explicitly targeting but would logically be impacted by the change in firm incentives). Our results specifically can inform state and federal regulators on the impact of reinsurance design and consumer welfare by carefully analyzing the case of Oregon's public reinsurance.

*required

Data Collection

Please indicate below the sources of information that will be used.

Data will be obtained directly from participant.

✓ Data will be obtained from a source with access to data.
Examples include school administrators, physicians office, etc.

*required

Will data include identifiers?

✓ No, or data will comprise a limited data set

Yes

None

*required

Data Storage

Please indicate where data will be stored.

✓ Computer

Please state owner of computer and any security measures (e.g., encryption, password protection, etc.) on the system.

Owned by Maura Coughlin, Assistant Professor of Economics, on a Rice IT configured and Rice-owned laptop within her locked campus office, accessed only in person or through secure Box access by either Dr. Coughlin or Salpy Kanimian.

Cloud/Offsite storage

Portable Storage Device

Hard Copy

Other

Data Security During Use, Analysis, and Transmission

Check all that apply

- ✓ Research staff will be trained on the proper handling of confidential and private data and information
- ✓ Data will be collected without identifiers
- Data will be reviewed and analyzed in secured/private space/office
- Certificate of Confidentiality will be obtained
- ✓ Data will be de-identified prior to sharing/transmission
- Data transmission will be encrypted end-to-end
- Data will be accessed only via secured data enclave/server via secured connection
- Other

Data Access

Check groups that may have access to study data

- ✓ Study personnel
- Funding agency
- Registries (*Data Repositories, Data Banks, Health Data Registries, etc.*)
- Other

Future Data Use and Sharing

Will data be stored and/or used for future studies?

- Yes
- ✓ No

Participants

Participant Categories

Please check below to indicate the groups of participants that will be taking part in the research program.

Rice Students

✓ Other Adults with Capacity for Consent
(*These are persons of the age of consent who do not have an illness that is expected to compromise their ability to offer informed consent, such as a neurodegenerative disorder.*)

Number of Participants

All adults 18-64 enrolled in an individual ACA marketplace health insurance plan in Oregon, approx 100,000-200,000 individuals annually.

✓ Pregnant Women

Number of Participants

Not known yet, only included in data set insofar as they are parts of the adult population described above.

Children

Adults with Diminished Capacity

Prisoners

*required

Total Number of Participants

Enter the sum of the participant groups above.
Fluctuates annually between around 100,000 and 200,000 people.

*required

Inclusion Criteria

Please list inclusion criteria, such as

- age
- sex or gender
- organizational association

Inclusion criteria should describe all persons who qualify as participants.

Individuals will be included in our requested data set if in any of the years 2014-2022 they are enrolled in one of Oregon's individual health insurance plans (ACA, or Obamacare, plans). As such they will be working age adults, not selected because of any other criteria.

*required

Exclusion Criteria

Please list exclusion criteria. These are considered to be characteristics that would rule out participants who would otherwise be candidate participants.

(For example, if your inclusion criteria were all adults, but participants were excluded from participation if they had high blood pressure, you would indicate high blood pressure here. You would not need to indicate that minors were excluded, as they are not within the included population.)

Not applicable.

*required

Will any language other than English be used during the study?

✓ No

Yes

*required

Compensation

Will participants receive compensation for participation in research?

Please ensure the following information is also in the Informed Consent.

Yes

Compensation Amount (in dollars or extra credit points)

Describe the amount that participants will be compensated. Please include pro-rating, if applicable.

Compensation Method

Describe how participants will be compensated (e.g., gift cards, cash, etc.)

Compensation Timing

Describe when participants will be paid (e.g., after each session, after completion of their participation, when the study ends, etc.)

✓ No

Recruitment

*required

Recruitment Practices

Please describe how recruitment will be performed. I.e., how will participants be informed of the study, how will they be provided with the informed consent, who will be involved in recruitment, etc.

If only Secondary Research is taking place, indicate so below.

Not applicable, as we are conducting Secondary Research using administrative data.

*required

Recruitment Documents

All recruitment documents (including copies of flyers, emails, social media posts, scripts for phone calls or radio ads) must be attached for review by the IRB.

Not applicable.docx

Informed Consent

*required

Documentation of Informed Consent

✓ Research will be limited to secondary data analysis; no informed consent will be necessary.

Participants will be fully informed, consent will be obtained and documented on a signed, written form.

Participants will be fully informed and consent will be obtained, but documentation of consent will be waived

Informed consent will be incomplete (e.g., deception of participants, etc.)

*required

Audio-Visual Recording

Please indicate here whether you will be collecting audio or audio-visual recordings of the research activities.
Please note that audio and audio-visual recordings are identifiable information.

Audio Recordings

Audio-Visual Recordings

✓ None

Non-Rice Affiliated Personnel

Training Certificate(s)

Materials for Interactions

Surveys

Evaluations/Tests/Inventories

Interview Questions

Focus Group Questions

Interventions

Multi-Site IRB Arrangements

IRB Reliance Agreement

Outside IRB Approval

Please upload the approval from the Reviewing IRB.

Study Protocol

Informed Consent Form

Please attach the Informed Consent Form from other institution(s).

International Research

Cultural Context Documents

International Research Approval

Deception Debriefing Statement

Research Involving Investigative Devices

IDE Exemption Form

FDA Letter for Approval of IDE

Research Involving Investigative Drugs

IND Exemption Form

Filed IND

FDA Approval Letter of IND

Informed Consent Forms

Informed Consent Form

Assent Form

Recruitment Materials

Not applicable.docx

Other Study Materials

SECTION 5: DATA MANAGEMENT & SECURITY

5.1 Data Reporting: APAC data or findings may not be disclosed in a way that can be used to re-identify an individual. Data with small numbers – defined as values of 30 or less (n≤30) or subpopulations of 50 or fewer individuals (n≤50) – cannot be displayed in findings or outputs derived from APAC data. Please describe the techniques you will use to prevent re-identification when findings or outputs result in small numbers or subgroups (e.g. aggregation, cell suppression, generalization, or perturbation).

We will adhere to all guidelines regarding the sensitivity of this data and our responsibility to minimize any risks to the individuals within the dataset. As such, we will not report data or statistics for which there are small numbers of people, as defined by APAC. As such, we will aggregate individuals as feasible, and when small numbers are unavoidable, we will suppress those values. Such care will be taken in analysis files and all published tables will not follow these precautions. We will make no attempts to reidentify individuals or link any individual data with additional data that might allow for reidentification. Additionally, our analysis primarily focuses on the insurer-level and thus will not display detailed individual data.

5.2 Data Linkage: OHA seeks to ensure that APAC data cannot be re-identified if it is linked or combined with data from other sources at the record, individual or address level. Requesters are strongly encouraged to consult with APAC staff regarding linking APAC data with other data prior to submitting a data request. Health Analytics prefers to conduct APAC data linking in-house and share only encrypted identifiers with data requesters.

a. *Does this project require linking to another resource?*

The only additional data our project requires is information about insurer private reinsurance activity. As such, we will not be linking individuals to other data sources, but we will be using additional information about the private reinsurance market to supplement what we know about insurance providers operating in the Oregon individual marketplace. The private reinsurance data will be obtained from insurer filings of Schedule S which is required and maintained by the National Association of Insurance Commissioners (NAIC). Schedule S data is state-firm aggregate level and includes for each insurer-private reinsurer pair, the insurance firm premium revenues (across all markets and not solely confined to ACA) spent on reinsurance purchases. No particular contract details and parameters are observed.

If yes, complete the parts b-d below.

b. *At what level the data will be linked?*

We will be linking at the insurance company level (payer_cd) as feasible.

c. *If required to link...*

N/A

d. Describe and justify all necessary linkages, including the key fields in each data set, how they will be linked, the software proposed to perform the linkage and why it is necessary.

If we are able to receive the data field for insurance carrier (payer_cd), we will collect the list of operating insurance companies in the market by year. For each company, we will include an annual total amount of private reinsurance. This is a very simple task technically, and can be done with either simple merge of a the additional table outlining reinsurance activity by company by year, or by hand entering the data alongside detailed notes describing source data. This single linkage is important for the analysis because firms will likely be making decisions regarding private reinsurance in light of the public reinsurance provided. Their risk exposure and decision-making should be impacted by their *total* reinsurance, and as such, we want to be able to control for their private reinsurance activities to the extent feasible.

e. Describe in detail the steps you will take to prevent re-identification of linked data.

N/A as the additional data is not connected to individuals.

5.3 Data Security (required for all applications):

a. Attach a detailed description of your plans to manage security of the APAC data including:

- *Designation of a single individual as the custodian of APAC data, either the principal investigator or staff listed in Section 2 of this application, who is responsible for oversight of APAC data, including reporting any breaches to OHA and ensuring the data are properly destroyed upon project completion.*

Custodian: Dr. Maura Coughlin will be responsible for data provision, including reporting any breaches to OHA and internal Rice IT and OIS staff. Dr. Coughlin will also be responsible for ensuring data are irretrievably destroyed after completion of the project.

- *A security risk management plan applicable to APAC data that includes:*
    - *Secure storage in any and all mediums (e.g., electronic or hard copy)*

Storage: Data will be transmitted using a secure file transfer protocol. It will be stored securely on an enterprise cloud-based storage called Box, set up, configured, and managed by Rice University's Office of Information Technology (OIT), and hosted on a compliant, Rice University-owned and configured computer under Dr. Coughlin's supervision. Data will be further stored in a workplace dedicated to this project, with limited shared access to this Rice University compliant computer by specific personnel named in this application.

- *Procedures to restrict APAC data access to only those individuals listed on the data use agreement*

Data access: Data will be only be permitted to one analyst and one PI, as listed in the application above.

- *User account controls, i.e., password protections, maximum failed login attempts, lockout periods after idle time, user audit logistic.*

User account controls: Appropriate precautions will be taken to ensure any risks related to breach of privacy or confidentiality. Box has technical security controls to defend the system against unauthorized login. The Rice University-owned computer on which the data will also be stored is password protected. We will follow Rice University's Office of Information Security guidance to ensure material is stored in a manner appropriate for its sensitivity.

- *Confirmation of training for personnel on how to properly manage protected health information in all formats*

Personnel training: The team members have completed a practicum on properly handling protected health information and personal data. Additionally, they have conducted training related to the Human and Research Protection Program, including the University's training through CITI. The PI, Dr Coughlin, will hold initial and regular meetings to plan data management and analyses to guide the analyst on the project.

- *Protection of derivatives of APAC data at the re-identifiable level*

Derivatives Protection: All derivatives of APAC data will be protected on our devices in the same manner as the original data with the same precautions taken. Derivatives will only be removed from the secure environment as results, all of which will be subject to the steps we describe above in terms of not reporting any individual or identifiable information, minimizing any risk of re-identification.

- *If applicable, procedures for handling direct identifiers, such as allowing access on a 'need to know' basis only and minimizing risk by storing identifiers separately from other APAC data*

We do not request direct identifiers.

- *Procedures for identifying, reporting and remedying any data breach*

Reporting: We will notify Rice University's Office of Information Technology, Rice University's Office of Information Security, and OHA in a timely fashion of any data breaches we become aware of by email and/or telephone call, including any outside access to a relevant device even if we cannot confirm APAC data was accessed. We will work with Rice's Office of Information Technology and their data security experts to remedy any specific breaches that may occur.

- *Statement of compliance with HIPAA and the HITECH Act*

Rice University's computing environment, without additional steps, is not HIPAA compliant. Under the advice of Rice University's Office of Information Security, our data request does not require HIPAA compliant protections, as it is de-identified. If ultimately it is deemed that the dataset is identifiable, and thus subject to HIPAA/HITECH, Rice's Office of Information Security is able to set up a secure computing environment for Dr. Coughlin that is HIPAA compliant, through collaboration with the storage capabilities of Rice University's partners at institutions here in Houston, such as the Baylor College of Medicine and MD Anderson.

- *Electronic device protections, i.e., anti-virus or anti-malware software, firewalls, and network encryption.*

Electronic device protections: Computing devices are equipped with electronic device protections, such as anti-virus/ anti-malware software. Rice University-owned computers are configured with rigorous and thorough software protections that are regularly updated by Rice's Office of Information Technology.

b. *Record level or derivative data that can be re-identified must be destroyed within 30 days of the end of the data use agreement, in a manner that renders it unusable, unreadable or indecipherable. What are your plans for destruction of the dataset and any potentially identifiable elements of the data once the data use agreement has expired?*

Destruction: We will follow the protocol within the executed DUAs regarding data destruction. After completing our analyses and finalizing results for publication and/or at the completion of the DUA, all corresponding data will be irretrievably deleted and destroyed. Destruction will be overseen by the Office of Information Technology (OIT) at Rice University using NIST SP 800-88 R1 guidelines for Media Sanitization at the termination of the project.

Please answer each of the following questions:

Please indicate the year(s) of data requested	2014-2022
Do you want people who are not Oregon residents and their claims included? People with Medicaid coverage or Medicare coverage reported by CMS are Oregon residents regardless of address.	No X
Do you want people with pharmacy coverage, but no medical coverage or claims included?	No X
Do you want people with dental coverage, but no medical coverage or claims included?	No X
Do you want orphan claims included? (claims, but no eligibility or coverage reported)	No X
Do you want denied claims included? (No reason is provided for denied medical or pharmacy claims. Claims can be denied then paid)	Yes X
Do you want pharmacy claims for people with pharmacy coverage, but no medical coverage or claims included?	No X
Do you want dental claims for people with dental coverage, but no medical coverage or claims included?	No X

What payer types do you want?	Commercial
	X - ACA marketplace insured people

One payer reported the claim status for all of their claims as fee-for-service for some years when most claims were encounter or managed care claims. Do you want the claim status changed to managed care?	Change to encounter
	X

What medical claim types do you want?	ALL
	X

Do you want to limit <u>medical claims</u> data to selected diagnoses, procedure or other codes?	No
	X

Do you want substance use disorder claims (SUD)? SUD claims were not available for request prior to APAC release 14. SUD requests require detailed information about purpose, hypotheses and analyses, information about data access, security, data destruction and data linking to any other source and detailed justification for requested data elements. Date use and release of information are restricted. Requires additional Data Use Agreement	No
	X

Do you want Coordination of Benefit (COB) medical claims?	Yes
	X

Do you want pharmacy claims?	Yes X
Do you want pharmacy claims for people with pharmacy coverage, but no medical coverage or claims included?	No X
Do you want Coordination of Benefit (COB) pharmacy claims?	Yes X
Do you want dental claims?	No X
Do you want dental claims for people with dental coverage, but no medical coverage or claims included?	No X
Do you want monthly eligibility data (insured/covered by month, by payer, by plan)?	Yes X
Do you want claims and eligibility data for selected age groups only?	Specify age range: 18-64 years old subscribers
Do you want to limit claims and eligibility data by sex/gender?	Include all X

Are you requesting identifiable data?	No
	X

Do you want provider data?	No
	X

Do you want APAC data linked to Oregon Center for Health Statitistics (CHS) Death Certificate data and/or Birth Certificate data? Please include a list of the birth and or death data variables that you plan to request from birth and/or death certificate data. You will need approval from both CHS and APAC. Submit request to APAC first. After APAC approval submit request to CHS and provide APAC approval notice. https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/Pages/Data-Use-Requests.aspx	No
	X

Is your requested APAC data going to be linked by the APAC Team or data requester to any other data source?	Yes, linked by data requester
	X

Only plan to link payers to private reinsurance data. We do not plan to link any individual level data.

Field Requested	Data Element	Security Level	Description	Justification (Please provide reason needed and minimum necessary for project)
The data elements highlighted in blue are provided in every data request	uid	De-Identified	A unique identifier that links to the row as submitted in the MC Intake File Layout. Used for linking tables/views	
	release_id	De-Identified	A value associated with the data release	
	mc059_service_start_dt	De-Identified	Date services for patient started	
	dw_claim_id	De-Identified	A unique medical claim identifier	
	mc005_line_no	De-Identified	Line number for the claim that begins with 1 and is incremented by 1 for each additional service line of a claim	
	uniquepersonID	De-Identified	A unique identifier for a person across payers and time	
	dw_member_id	De-Identified	A payer & plan specific unique identifier for a person. A person can have multiple member IDs for a single payer because they can have multiple plans. DW_member_IDs are not unique identifiers for a person across payers and years	
	dw_person_id	De-Identified	Vendor identifier for a person across payers and time-2 million people assigned more than one identifier	
	mc038_claim_status_cd	De-Identified	Claim status. P (Paid), D (Denied), C - (MCO/CCO encounter) E (other)	
	mc038a_cob_status	De-Identified	Coordination of benefit claim. Indicates secondary payer for a claim	

	orphan_fl	De-Identified	Identifies orphan claim with no corresponding eligibility for the date of service. 1 (Yes), 0 (No)	
	mc003_insurance_product_type_cd	De-Identified	A code that indicates an insurance coverage type. Data element required for linking claims to member months	
	member_state	De-Identified	People with Medicaid coverage and people with Medicare coverage reported by the Centers for Medicare & Medicaid Services are Oregon residents regardless of reported address	
	Suppressed_FI	De-Identified	1 (denied claim line), 0 (other than denied)	
	RemovedReversal_FI	De-Identified	1 (claims not included before release 13 because the charge, paid amount, and allowed amounts are zero or zero when summed across claim lines and after the removal of denied claim lines, 0 (otherwise)	
X	mc060_service_end_dt	De-Identified	Date services for patient ended	Need to both track claims and corresponding expenditure - including the timing of claims - but also to characterize claim processing.

X	COB	De-Identified	Links primary and secondary payer claims based on uniquepersonID, date, charged amount, procedure code and provider and identifies the primary payer claim, secondary payer claim and COBonly claim when there is no linked primary claim	Needed to track claims and cumulative cost by individual.
X	Claim_LOB	De-Identified	Payer line of business: 1 (Medicare), 2 (Medicaid), 3 (commercial, 0 (no line of business reported)	Only requesting commercial ACA enrollees - if receive just tat then we do not need this variable.
X	mc207_payment_type	De-Identified	Indicates the payment methodology: 01 (Capitation); 02 (Fee for Service); 07 (Other)	To fully characterize cumulative costs.
X	mc001_payer_type	De-Identified	Payer reported payer type codes:(C) Carrier, (D) Medicaid, (G) Other government agency, (P) Pharmacy benefits manager, (T) Third-party administrator, (U) Unlicensed entity	To extent varies across insurers, control for it.
X	mc018_admit_dt	De-Identified	Admission date	Need to both track claims and corresponding expenditure - including the timing of claims.
X	mc203_admit_type_cd	De-Identified	Admission type:1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (missing)	To characterize claims and services and the control for in claims processing decisions.

X	mc204_admission_source_cd	De-Identified	Admission source	To characterize claims and services and the control for in claims processing decisions.
X	mc205_admit_diagnosis_cd	De-Identified	Admitting diagnosis. ICD-10 diagnosis code for dates of service beginning 10/01/2015, ICD-9 diagnosis code for dates of service before 10/01/2015	To characterize claims and services and the control for in claims processing decisions.
X	mc070_discharge_dt	De-Identified	Discharge date-required for inpatient hospitalization	To characterize claims and services and the control for in claims processing decisions.
X	mc023_discharge_status_cd	De-Identified	Status for member discharged from a hospital	To characterize claims and services and the control for in claims processing decisions.
X	LOS	De-Identified	Length of stay of inpatient admission measured in days. Discharge Date - Admit Date. <1 is rounded to 1. Negative values set to NULL	To characterize claims and services and the control for in claims processing decisions.
X	mc036_bill_type_cd	De-Identified	Type of bill on uniform billing form (UB)	To characterize claims and services and the control for in claims processing decisions.
X	mc037_place_of_service_cd	De-Identified	Industry standard place of service code	To characterize claims and services and the control for in claims processing decisions.
X	mc054_revenue_cd	De-Identified	Revenue code	To fully characterize claims costs.

X	mc041_principal_diagnosis_cd	De-Identified	Principal Diagnosis code	To characterize claims and services and the control for in claims processing decisions.
X	mc041p_poa_p	De-Identified	Required present on admission flag for diagnosis 1: Yes, no, W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	To characterize claims and services and the control for in claims processing decisions.
X	mc042_other_diagnosis_2	De-Identified	Additional Diagnosis 2	To characterize claims and services and the control for in claims processing decisions.
X	mc042p_poa_2	De-Identified	Required POA flag for diagnosis 2 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc043_other_diagnosis_3	De-Identified	Additional Diagnosis 3	To characterize claims and services and the control for in claims processing decisions.
X	mc043p_poa_3	De-Identified	Required POA flag for diagnosis 3 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc044_other_diagnosis_4	De-Identified	Additional Diagnosis 4	To characterize claims and services and the control for in claims processing decisions.

X	mc044p_poa_4	De-Identified	Required POA flag for diagnosis 4 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc045_other_diagnosis_5	De-Identified	Additional Diagnosis 5	To characterize claims and services and the control for in claims processing decisions.
X	mc045p_poa_5	De-Identified	Required POA flag for diagnosis 5 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc046_other_diagnosis_6	De-Identified	Additional Diagnosis 6	To characterize claims and services and the control for in claims processing decisions.
X	mc046p_poa_6	De-Identified	Required POA flag for diagnosis 6 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc047_other_diagnosis_7	De-Identified	Additional Diagnosis 7	To characterize claims and services and the control for in claims processing decisions.
X	mc047p_poa_7	De-Identified	Required POA flag for diagnosis 7 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc048_other_diagnosis_8	De-Identified	Additional Diagnosis 8	To characterize claims and services and the control for in claims processing decisions.

X	mc048p_poa_8	De-Identified	Required POA flag for diagnosis 8 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc049_other_diagnosis_9	De-Identified	Additional Diagnosis 9	To characterize claims and services and the control for in claims processing decisions.
X	mc049p_poa_9	De-Identified	Required POA flag for diagnosis 9 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc050_other_diagnosis_10	De-Identified	Additional Diagnosis 10	To characterize claims and services and the control for in claims processing decisions.
X	mc050p_poa_10	De-Identified	Required POA flag for diagnosis 10 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc051_other_diagnosis_11	De-Identified	Additional Diagnosis 11	To characterize claims and services and the control for in claims processing decisions.
X	mc051p_poa_11	De-Identified	Required POA flag for diagnosis 11 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc052_other_diagnosis_12	De-Identified	Additional Diagnosis 12	To characterize claims and services and the control for in claims processing decisions.

X	mc052p_poa_12	De-Identified	Required POA flag for diagnosis 12 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc053_other_diagnosis_13	De-Identified	Additional Diagnosis 13	To characterize claims and services and the control for in claims processing decisions.
X	mc053p_poa_13	De-Identified	Required POA flag for diagnosis 13 if populated	To characterize claims and services and the control for in claims processing decisions.
X	mc201_icd_version_cd	De-Identified	Identifies ICD9 or ICD10 version	Needed to accurately translate diagnosis codes to describe patient conditions/severity.
X	mc055_procedure_cd	De-Identified	Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS)	To characterize claims and services and the control for in claims processing decisions.
X	mc056_procedure_modifier_1_cd	De-Identified	CPT or HCPCS modifier	To characterize claims and services and the control for in claims processing decisions.
X	mc057_procedure_modifier_2_cd	De-Identified	CPT or HCPCS modifier	To characterize claims and services and the control for in claims processing decisions.

X	mc057a_procedure_modifier_3_cd	De-Identified	CPT or HCPCS modifier	To characterize claims and services and the control for in claims processing decisions.
X	mc057b_procedure_modifier_4_cd	De-Identified	CPT or HCPCS modifier	To characterize claims and services and the control for in claims processing decisions.
X	APACgrouper	De-Identified	Groups all lines of a claim in prioritized order as inpatient, emergency department, outpatient, professional, pharmacy and other based on type of bill, revenue and place of service codes	To characterize claims and services and the control for in claims processing decisions.
X	claim_type	De-Identified	Vendor generated claim ltype. Identifies claim lines as inpatient facility claim (1), outpatient facility claim (2) and professional claim (3) based on bill type, revenue code and place of service. Null means claim line type could not be determined.	To characterize claims and services and the control for in claims processing decisions.
X	mc058_icd_primary_procedure_cd	De-Identified	The main inpatient procedure code	To characterize claims and services and the control for in claims processing decisions.
X	mc058a_icd_procedure_2	De-Identified	Inpatient procedure ICD-10 code 2	To characterize claims and services and the control for in claims processing decisions.
X	mc058b_icd_procedure_3	De-Identified	Inpatient procedure ICD-10 code 3	To characterize claims and services and the control for in claims processing decisions.

X	mc058c_icd_procedure_4	De-Identified	Inpatient procedure ICD-10 code 4	To characterize claims and services and the control for in claims processing decisions.
X	mc058d_icd_procedure_5	De-Identified	Inpatient procedure ICD-10 code 5	To characterize claims and services and the control for in claims processing decisions.
X	mc058e_icd_procedure_6	De-Identified	Inpatient procedure ICD-10 code 6	To characterize claims and services and the control for in claims processing decisions.
X	mc058f_icd_procedure_7	De-Identified	Inpatient procedure ICD-10 code 7	To characterize claims and services and the control for in claims processing decisions.
X	mc058g_icd_procedure_8	De-Identified	Inpatient procedure ICD-10 code 8	To characterize claims and services and the control for in claims processing decisions.
X	mc058h_icd_procedure_9	De-Identified	Inpatient procedure ICD-10 code 9	To characterize claims and services and the control for in claims processing decisions.
X	mc058j_icd_procedure_10	De-Identified	Inpatient procedure ICD-10 code 10	To characterize claims and services and the control for in claims processing decisions.
X	mc058k_icd_procedure_11	De-Identified	Inpatient procedure ICD-10 code 11	To characterize claims and services and the control for in claims processing decisions.

X	mc058l_icd_procedure_12	De-Identified	Inpatient procedure ICD-10 code 12	To characterize claims and services and the control for in claims processing decisions.
X	mc058m_icd_procedure_13	De-Identified	Inpatient procedure ICD-10 code 13	To characterize claims and services and the control for in claims processing decisions.
X	mc201_icd_version_cd	De-Identified	ICD version code 9 - ICD-9, 10 - ICD-10	Needed to accurately translate diagnosis codes to describe patient conditions/severity.
X	final_mdc	De-Identified	a code identifying the final Major Diagnostic Category (MDC)	To characterize claims and services and the control for in claims processing decisions.
X	final_drg	De-Identified	a code indentifying the final Diagnosis Related Group	To characterize claims and services and the control for in claims processing decisions.
X	final_ms_ind	De-Identified	a flag indicating if final_mdc is medical or surgical	To characterize claims and services and the control for in claims processing decisions.
X	drg description	De-Identified	Final DRG description	To characterize claims and services and the control for in claims processing decisions.

X	mdc description	De-Identified	Final MDC description	To characterize claims and services and the control for in claims processing decisions.
X	MS DRG MDC cross walk Description	De-Identified	Crosswalk DRG to MDC	To characterize claims and services and the control for in claims processing decisions.
X	mc061_service_qty	De-Identified	count of units reported on claim line	To characterize claims and services and the control for in claims processing decisions.
X	mc017_paid_dt	De-Identified	Payment date	Need to both track claims and corresponding expenditure - including the timing of claims - but also to characterize claim processing.
X	mc062_charge_amt	De-Identified	Payer reported charges or billed amount for the service	Need to both track claims and corresponding expenditure - including the timing of claims - but also to characterize claim processing.

X	mc063_paid_amt	De-Identified	Payment made by payer. Does not include expected copayment, coinsurance or deductible by the member	Need to both track claims and corresponding expenditure - including the timing of claims - but also to characterize claim processing.
X	mc065_copay_amt	De-Identified	Expected Co-payment by the member and $0 patientpaid	To track spend and costs to patient and insurer and characterize plans.
X	mc066_coinsurance_amt	De-Identified	Expected Co-insurance by the member and $0 patientpaid	To track spend and costs to patient and insurer and characterize plans.
X	mc067_deductible_amt	De-Identified	Expected Deductible by the member and $0 patientpaid	To track spend and costs to patient and insurer and characterize plans.
X	patientpaid	De-Identified	Expected Patient paid amount. Amount patient paid when sum of copayment,coinsurance and deductible is less than the amount of mc067a_patient_paid_amt reported	To track spend and costs to patient and insurer and characterize plans.
~~X~~	~~Zeropaid_FL~~	~~De-Identified~~	~~All lines in a claim paid zero dollars~~	~~To track spend and costs to patient and insurer and characterize plans.~~
~~X~~	~~NoCOB_Zeropaid_ALandCh0_fl~~	~~De-Identified~~	~~All lines in a claim paid zero dollars and the allowed amount or charged amount > $0 and the claim is not a coordination of benefit claims~~	~~To track spend and costs to patient and insurer and characterize plans.~~

X	LowPaid_fl	De-Identified	All lines in a claims sum to less than $4 paid	To track spend and costs to patient and insurer and characterize plans.
X	mc202_provider_network_indicator	De-Identified	Indicator of service received in or out of network:1 (in network), 2 (National network), 3 (out-of-network)	To characterize claims and services and the control for in claims processing decisions.
X	dw_rendering_provider_id	De-Identified	A unique identifier associated with a unique rendering provider across plans, payers and years	To characterize claims and services and the control for in claims processing decisions.
X	dw_billing_provider_id	De-Identified	A unique identifier associated with a unique billing provider across plans, payers andyears	To characterize claims and services and the control for in claims processing decisions.
X	rendering_hospital_id	Limited	Hospital that rendered services	Helpful to control for in claims processing.
X	billing_hospital_id	Limited	Hospital billed for services	Helpful to control for in claims processing.
X	rendering_asc_id	Limited	Ambulatory surgery center that rendered services	Helpful to control for in claims processing.
X	billing_asc_id	De-Identified	Ambulatory surgery center billed or services	To characterize claims and services and the control for in claims processing decisions.
X	age	De-Identified	Age on date of service	Either yob or age; to control for insurer anticipated spend and differential insurer behavior

~~X~~	~~yob~~	~~De-Identified~~	~~Year of Birth. Null If no date of birth was reported~~	~~Either yob or age; to control for insurer anticipated spend and differential insurer behavior~~
X	me013_member_gender_cd	De-Identified	member's gender F = Female, M = Male, U = Unknown	To control for insurer anticipated spend and additional verification of designation of individuals within plan and to measure possible differential insurer behaviors.
X	urban_fl	De-Identified	Zip codes grouped into urban and rural identified by OHA	To control for insurer anticipated spend and additional verification of designation of individuals within plan and to measure possible differential insurer behaviors.
X	member_zip_three	De-Identified	First three characters of member zip code from the date of service	To control for insurer anticipated spend and additional verification of designation of individuals within plan and to measure possible differential insurer behaviors.
X	interim_fl	De-Identified	Flag identifying interim bills	Helpful to control for in claims processing.

X	interim_claim_id	De-Identified	Unique identifier set by DW_Claim_ID of the initial interim claim	Helpful to control for in claims processing.
Data elements that are frequently denied				
~~X~~	~~payer_cd~~	~~Sensitive~~	~~Payer name abbreviation code~~	~~Important (key) variable for our analyses. We are evaluating insurer claims processing behavior at different levels of patient spend. As such, we need to assign claim processing behavior to insurers and account for the additional private reinsurance the firms purchase in the market (to determine the total impact the public reinsurance policies within the ACA market have on insurers).~~
X	mc062a_allowed_amt	Limited	Allowed amount	To accurately track individual costs to insurer to compare to the kink points of the reinsurance schedule.

Field Requested	Data Element	Security Level	Description	Justification (Please provide reason needed and minimum necessary for project)
The data elements highlighted in blue are provided in every data request	uid	De-Identified	A unique identifier that links to the row as submitted in the PC Intake File Layout. Used for linking tables/views	
	release_id	De-Identified	A value associated with the data release	
	dw_claim_id	De-Identified	A unique medical claim identifier	
	pc032_prescription_fill_dt	De-Identified	Prescription fill date	
	dw_member_id	De-Identified	A payer & plan specific unique identifier for a person. A person can have multiple member IDs for a single payer because they can have multiple plans. DW_member_IDs are not unique identifiers for a person across payers and years	
	uniquepersonID	De-Identified	A unique identifier for a person across payers and time	
	dw_person_id	De-Identified	Vendor identifier for a person across payers and time-2 million people assigned more than one identifier	
	pc025_claim_status_cd	De-Identified	Claim status. P (Paid), D (Denied), C - (MCO/CCO encounter) E (other)	
	pc003_insurance_product_type_cd	De-Identified	A code that indicates an insurance coverage type	
	orphan_fl	De-Identified	Identifies orphan claim with no corresponding eligibility for the date of service. 1 (Yes), 0 (No)	

	member_state	De-Identified	People with Medicaid coverage and people with Medicare coverage reported by the Centers for Medicare & Medicaid Services are Oregon residents regardless of reported address	
	Suppressed_FI	De-Identified	1 (denied claim line), 0 (other than denied)	
	RemovedReversal_FI	De-Identified	1 (claims not included before release 13 because the charge, paid amount, and allowed amounts are zero or zero when summed across claim lines and after the removal of denied claim lines, 0 (otherwise)	
X	pc025_claim_status_cd	De-Identified	Claim status. P - Paid,C - CCO encounter, E - other	Needed to track spending and characterize claim processing.
X	COBDup	De-Identified	Links claims based on uniquepersonID, date, pc_026_drug_cd, charged amount, and provider and identifies an event that could be either COB claim or duplicate paid claim	Needed to track claim spending by individual.
X	pc001_payer_type	De-Identified	Payer reported payer type codes:(C) Carrier, (D) Medicaid, (G) Other government agency, (P) Pharmacy benefits manager, (T) Third-party administrator, (U) Unlicensed entity	To the extent it varies, want to be able to control for it when accounting for payer behavior.
X	Claim_LOB	De-Identified	Payer line of business: 1 (Medicare), 2 (Medicaid), 3 (commercial, 0 (no line of business reported)	We are requesting just ACA (commercial non-group), so should not be needed.

X	dw_pharmacy_id	De-Identified	A unique identifier associated with a unique pharmacy across plans, payers and years	Helpful for learning about pharmacy network and that impact on costs.
	dw_prescribing_provider_id	De-Identified	A unique identifier associated with a unique prescribing provider across plans, payers and years	Helpful for controlling for in claims processing.
X	pc021_pharmacy_npi	De-Identified	Pharmacy's National Provider Identifier (NPI)	Helpful for learning about pharmacy network and that impact on costs.
	pc021a_pharmacy_alt_id	De-Identified	Pharmacy's alternate identifier as assigned by the payer	Helpful for learning about pharmacy network and that impact on costs.
X	pc020_pharmacy_name	De-Identified	Name of pharmacy	Helpful for learning about pharmacy network and that impact on costs.
X	pc022_pharmacy_city	De-Identified	City of pharmacy	Helpful for learning about pharmacy network and that impact on costs.
X	pc048_prescribing_physician_npi	De-Identified	Identifier for the provider who prescribed the medication as assigned by the reporting entity	Helpful for controlling for in claims processing.
X	pc026_drug_cd	De-Identified	National Drug Code (NDC)	To characterize claims and services and the control for in claims processing decisions.

X	pc033_dispensed_qty	De-Identified	Quantity dispensed	To characterize claims and services and the control for in claims processing decisions.
X	pc034_days_supply_qty	De-Identified	Number of days that the drug will last if taken at the prescribed dose	To characterize claims and services and the control for in claims processing decisions.
X	pc030_dispense_as_written_cd	De-Identified	Dispense as written. Indicates if drug substitution authorized	To characterize claims and services and the control for in claims processing decisions.
X	pc028_calc_refill_no	De-Identified	Processor's count of times prescription refilled	Helpful for controlling for in claims processing.
X	pc031_compound_drug_ind	De-Identified	Indicates if it is a compound drug, 1 (no), 2 (yes), Null	To characterize claims and services and the control for in claims processing decisions.
X	pc017_paid_dt	De-Identified	Prescription Payment date	Need for tracking cumulative spend and assessing where in the course of year spending the claim falls.
X	pc036_paid_amt	De-Identified	Payment made by payer. Does not include expected copayment, coinsurance or deductible by the member 0 if amt=0, blank if missing	Need for tracking cumulative spend and assessing where in the level of year spending the claim falls.

X	pc035_charge_amt	De-Identified	Payer reported charges or billed amount for the service 0 if amt=0, blank if missing	Need for tracking cumulative spend and assessing where in the level of year spending the claim falls.
X	pc040_copay_amt	De-Identified	Expected Co-payment by the member and $0 patientpaid	To account for in spend tracking and characterizing plans.
X	pc041_coinsurance_amt	De-Identified	Expected Co-insurance by the member and $0 patientpaid	To account for in spend tracking and characterizing plans.
X	pc042_deductible_amt	De-Identified	Expected Deductible by the member and $0 patientpaid	To account for in spend tracking and characterizing plans.
X	patientpaid	De-Identified	Expected Patient paid amount. Amount patient paid when sum of copayment,coinsurance and deductible is less than the amount of pc043_patient_paid_amt reported	To account for in spend tracking and characterizing plans.
X	age	De-Identified	Member age in years calculated on the first day of the month	Either yob or age; to control for insurer anticipated spend and differential insurer behavior
~~X~~	~~yob~~	~~De-Identified~~	~~Year of Birth from Member_DOB field from Member DAV. If no date of birth has been reported, NULL~~	~~Either yob or age; to control for insurer anticipated spend and differential insurer behavior~~

X	member_zip_three	De-Identified	First three characters of member's zip code	For controlling in claim spend amounts and insurer anticipated costs.
X	urban_fl	De-Identified	Zip codes grouped into urban and rural identified by OHA	For controlling in claim spend amounts and insurer anticipated costs.
Data elements that are frequently denied				
~~X~~	~~payer_cd~~	~~Sensitive~~	~~Payer name abbreviation code~~	~~Important variable for our analyses. We are evaluating insurer claims processing behavior at different levels of patient spend. As such, we need to assign claim processing behavior to insurers and account for the additional private reinsurance the firms purchase in the market (to determine the total impact the public reinsurance policies within the ACA market have on insurers).~~
~~X~~	~~pc008_subscriber_contract_no~~	~~Sensitive~~	~~Plan-specific contract number~~	~~Do not need/not requested if payer_cd is provided.~~

Field Requested	Data Element	Security Level	Description	Justification (Please provide reason needed and minimum necessary for project)
The data elements highlighted in blue are provided in every data request	uid	De-Identified	A unique identifier that links to the row as submitted in the MM Intake File Layout. Used for linking tables/views	
	release_id	De-Identified	A value associated with the data release	
	year_Eligibility	De-Identified	Year of eligibility	
	month_Eligibility	De-Identified	Month of eligibility	
	dw_member_id	De-Identified	A unique identifier associated with a single plan and payer and assigned to all eligibility and claims records associated with a given individual for that plan/payer. An individual can have multiple member ids for a payer because they can have multiple plans.	
	uniquepersonID	De-Identified	A unique identifier for a person across payers and time	
	dw_person_id	De-Identified	Vendor identifier for a person across payers and time-2 million people assigned more than one identifier	
	me003_insurance_product_type_cd	De-Identified	A code that indicates an insurance coverage type	
	me018_medical_coverage_flag	De-Identified	Medical Coverage Flag not required when ME001=E	
	me019_prescription_drug_coverage_flag	De-Identified	Prescription Drug coverage flag	
	me207_dental_coverage_flag	De-Identified	Flag indicates dental coverage for the month	

	member_state	De-Identified	People with Medicaid coverage and people with Medicare coverage reported by the Centers for Medicare & Medicaid Services are Oregon residents regardless of reported address	
X	Month_Start	De-Identified	Date of Eligibility set to the first of the month	Needed to characterize coverage year spend by individual - need to know approximately when they have coverage.
X	Me005a_plan_term_dt	De-Identified	Plan termination date	Needed to characterize coverage year spend by individual - need to know approximately when they have coverage.
X	LOB	De-Identified	Payer line of business: 1 (Medicare), 2 (Medicaid), 3 (commercial, 0 (no line of business reported)	Do not need if only receive commercial (ACA) as requested.
X	me012_member_subscriber_rlp_cd	De-Identified	Relationship code	Reinsurance policies at individual level - need to track spending for separate individuals within a plan.
X	me013_member_gender_cd	De-Identified	Member Gender:M (male), F (female), and U (unknown)	To control for insurer anticipated spend and additional verification of designation of individuals within plan.

~~X~~	~~yob~~	~~De-Identified~~	~~Year of Birth from Member_DOB field from Member DAV. If no date of birth has been reported, NULL~~	~~Either yob or age; to control for insurer anticipated spend and differential insurer behavior~~
X	age	De-Identified	Member age in years calculated on the first day of the month	Either yob or age; to control for insurer anticipated spend and differential insurer behavior
X	me202_market_segment_cd	De-Identified	Market Segment	We are focused only on commercial, non-group (ACA) coverage. If sample limited to those, we do not need this variable.
X	me203_metal_tier	De-Identified	Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the ACA:0 (Not a QHP or catastrophic plan), 1 (catastrophic), 2 (bronze), 3 (silver), 4 (gold), 5 (platinum)	Control for anticipated insurer spend, as well as track differential behavior by insurer across plan types.
X	me205_high_deductible_health_flag	De-Identified	High Deductible Health Plan Flag	To track spend and costs to patient and insurer and characterize plans.
X	me206_primary_insurance_ind	De-Identified	Flag indicates primary insurance	To track patient spend by insurer.
X	urban_fl	De-Identified	Zip codes grouped into urban and rural identified by OHA	For controlling in claim spend amounts and insurer anticipated costs.

X	member_zip_three	De-Identified	First three characters of member zip code from the date of eligibility	For controlling in claim spend amounts and insurer anticipated costs.
X	rarestre	De-Identified	The rarest race-ethnicity identified for a person across payers and years (only one identified per person): (P) Native Hawaiian or Pacific Islander, (B) Black or African American, (I) American Indian or Alaskan Native, (A) Asian, (H) Hispanic or Latino, (W) White, (O) other and (noRE) no race-ethncity reported	For determining any differential insurer responses.
X	re1_race_cd	De-Identified	All races reported by all payers for all years for a person: (P) Native Hawaiian or Pacific Islander, (B) Black or African American, (I) American Indian or Alaskan Native, (A) Asian, (W) White, (O) other, (U) unknown, (R) refused and null	For determining any differential insurer responses.
X	re2_ethncity_cd	De-Identified	All ethnicities reported by all payers for all years for a person: (H) Hispanic), (O) Not Hispanic, (U) unknown, (R) refused and null	For determining any differential insurer responses.
X	re3_primary_language_cd	De-Identified	All primary spoken languages reported by all payers for all years for a person	For determining any differential insurer responses.
Data elements that are frequently denied				

X	payer_cd	Sensitive	Payer name abbreviation code	Important variable for our analyses. We are evaluating insurer claims processing behavior at different levels of patient spend. As such, we need to assign claim processing behavior to insurers and account for the additional private reinsurance the firms purchase in the market (to determine the total impact the public reinsurance policies within the ACA market have on insurers).

From: Maura Coughlin
To: OHPR - APAC Admin
Subject: RE: Data use application
Date: Wednesday, August 28, 2024 2:44:17 PM

Hi,

Following my discussion today with the team at APAC I would like to amend my request to do a phased approach. I would like to begin initially without the payer codes in my data request and amend that in phase 2 with additional detail following the meeting next month to clarify the trade secret requirements from the insurers.

Thank you very much and please let me know if any additional information is needed at this time.

Best,
Maura Coughlin

From: Maura Coughlin <maura.coughlin@rice.edu>
Sent: Thursday, August 15, 2024 10:15 AM
To: 'OHPR - APAC Admin' <APAC.Admin@odhsoha.oregon.gov>
Cc: 'Maura Coughlin' <maura.coughlin@rice.edu>
Subject: Data use application

Hi,

Attached are my application materials for a limited use data application to conduct academic research. I have been working with the research and IT staff here at Rice University in preparation. If there are any issues with my application regarding data management, please let me know. Rice's staff has the ability to provide additional resources, but generally does not do so unless specifics are requested.

If any additional information or clarifications would be helpful or there are any questions, please don't hesitate to contact me to clarify or revise.

Thank you for your time reviewing this.
Best,
Maura Coughlin

New or Amended APAC Data Request Review (custom or OHA Business Associate)

Staff Reviewer: Oliver

DRTS Number: 6364

Date review completed: 10/8/2024

	Yes	No	N/A	Need more information
Is this a new APAC request?	X			
New APAC Request (skip to next section if amendment request):				
1.1 Project staff contact information provided	X			
1.2 Project technical staff information provided	X			
2.1 Project summary provided with adequate detail to identify a specific unambiguous project	X			Research is now phased. Phase 1 will be foundational work necessary to move forward to Phase 2. In Phase 2 requester seeks to identify payers.
2.2 Research questions provided with adequate detail	X			
2.3 Described planned products and reports derived from requested data	X			Academic papers and presentations
2.4 Project begin and end date provided	X			End 9/1/2027
2.5 Acknowledgement that APAC data cannot be reused beyond the DUA	X			
2.5 Acknowledgement that data cannot be shared beyond the DUA	X			
3.1ab Data request purpose box checked & description	X			Research
3.2 Checked box for level of data identifiers	X			Limited
3.3 IRB application, approval memo, end date	X			Exempt
4.1 Completed data elements workbook	X			ACA plans only, ages 18-64
4.2 Adequately described how the data elements requested are the minimum necessary	X			Justifications are very thorough. Payer identifiers will not be provided in Phase 1.
5.1 Plan provided to prevent re-identification	X			
5.2ab Plan to link APAC data to other data source	X			Link to NAIC data in Phase 2
5.2c Requests OHA to link APAC to other data		X		
5.2d Detailed data linking plan provided			X	Link by payer name in Phase 2
5.3 Provided adequate description of data management, security and data destruction plan	X			
Passes Minimum Necessary Review	X			Review is for Phase 1, in which payers will not be identified. Request is for a small slice of commercial claims that are relevant to requester's research.

Recommend management approval	**X**			Recommend approving Phase 1. Phase 2 is dependent upon (1) the outcome of trade secret discussions with payers and (2) successful completion of phase 1.