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2016 Health Care Cost and Utilization Report

Analytic Methodology

2016V1.0

January 23, 2018

Note: This analytic methodology is appropriate for the *2016 Health Care Cost and Utilization Report*, as our methods are continually refined. Interested parties are encouraged to refer to the appropriate methodology and report.

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1. Introduction

For the *2016 Health Care Cost and Utilization Report*, the Health Care Cost Institute (HCCI) presented national and subnational benchmarked statistics of health care spending, utilization, prices, and service intensity for the population of individuals younger than 65 and covered by employer-sponsored private health insurance (ESI). The data behind these statistics came from a national, multipayer, commercial health care claims database created by HCCI containing information provided by four major insurers. As of July 2017, HCCI held approximately 1 billion commercial medical and pharmacy claims per year, representing the health care activity of more than 50 million individuals per year for the years 2007 through 2016. This document, the latest in a series of analytic methodologies from HCCI, describes in detail the methods used to transform raw claims into descriptive statistics.

For the annual *Health Care Cost and Utilization* reports and semi-annual *Children's Health Spending* reports, HCCI produced an analytic subset of its database, consisting of all non-Medicare claims on behalf of beneficiaries younger than age 65, covered by ESI and whose claims were filed with a contributing health plan between 2012 and 2016. Figure 1 shows the process HCCI used to clean the employer-sponsored health insurance claims data. It categorized claims, flagged chronically ill populations, calculated utilization, and determined resource intensity weights. HCCI made this data representative of the national population younger than 65 and having ESI using population weights based on U. S. Census Bureau data. For data from the years of 2015 and 2016, HCCI used a completion method to estimate the components of claims that were incomplete at the end of the reporting period. No adjustment was performed for inflation, so the estimated dollars in these reports are nominal.



FIGURE 1: PROCESS FLOW



A note on premiums

HCCI does not report on premiums or their determinants. For more information on health insurance premiums and the multiple factors that affect them (including health care expenditures; insured, group, and market characteristics; benefit design; and the regulatory environment), see Congressional Research Service, *Private Health Insurance Premiums and Rate Reviews, 2011*; ¹ American Academy of Actuaries, *Critical Issues in Health Reform: Premium Setting in the Individual Market, 2010*; ² and Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals, Chapter 3, Factors Affecting Insurance Premiums, 2008*.³

Changes in the methodology (August 2017)

Compared to earlier versions, HCCI's updated analytic methodology (2016V1.0) had a number of changes designed to respond to inquiries about methods and enhance reporting.

- For the 2016 analytic dataset, 2012, 2013, and 2014 data were considered complete, and no actuarial adjustment was performed. The 2015 and 2016 claims were actuarially completed using the new data.
- The average intensity weights were changed to reflect updates to DRGs, RVUs, and APCs by CMS in 2016.
- The census data used to create the population weighting changed for this analytic dataset as the previously used 3-year average population metrics were discontinued in 2015. See Section 2.5.2 for more information.



2. Methods

2.1 Data collection

HCCI has access to health care claims data for approximately 50 million Americans in every year between 2007 and 2016. This dataset was developed from de-identified claims data that were compliant with the Health Insurance Portability and Accountability Act (HIPAA) and included the allowed cost (actual prices paid) to providers for services. To produce the findings in the *2016 Health Care Cost and Utilization Report*, HCCI used an analytic subset of its data consisting of all eligible claims for insureds younger than age 65 and covered by either fully-insured or self-insured employer-sponsored health insurance (ESI). The final analytic subset consisted of just under 40 million covered lives per year, for the years 2012 through 2016 (Table 1). The claims used in the 2015 report, 4.6 billion claim lines, represent the health care activity of about 26% of all individuals younger than 65 and having ESI, making this one of the largest data collections on the privately insured ever assembled.

TABLE 1: ANALYTIC SUBSET FOR 2016 REPORT – TOTAL COVERED LIVES BY CALENDAR YEAR

<u>Year</u>	<u>Covered Lives</u>
2012	39,400,000
2013	39,800,000
2014	40,000,000
2015	39,500,000
2016	40,300,000

Source: HCCI, 2018. Notes: Data refer only to HCCI holdings of claims for beneficiaries covered by employer-sponsored health insurance and younger than age 65. HCCI datasets include additional data on the individually insured, Medicare Advantage, and other covered beneficiaries not used in these reports. Data rounded to the nearest 100,000.

Between January 2017 and July 2017, each contributing insurer updated the 2015 claims data they previously submitted to HCCI in addition to providing new data from 2016. HCCI's data manager confirmed the data integrity of each claims file (membership, medical, and pharmacy) in each year with the appropriate data contributor.

From these base datasets, a single analytical dataset was constructed for analysis using



the process shown in Figure 1. Analysis of the analytic dataset is described in Section 3.

2.2 Claims categorization

At the highest level, claims data were grouped into four major service categories: inpatient facility, outpatient facility, professional procedure, and prescription drugs and devices. HCCI also divided claims into several subservice categories: acute inpatient, which excludes skilled nursing facilities, hospice, and ungroupable claims; outpatient facility visits; outpatient-other claims; brand prescriptions; and generic prescriptions. Claims were further classified into detailed service categories (see Appendix Tables 4.1, 4.3, 4.4, and 4.5).

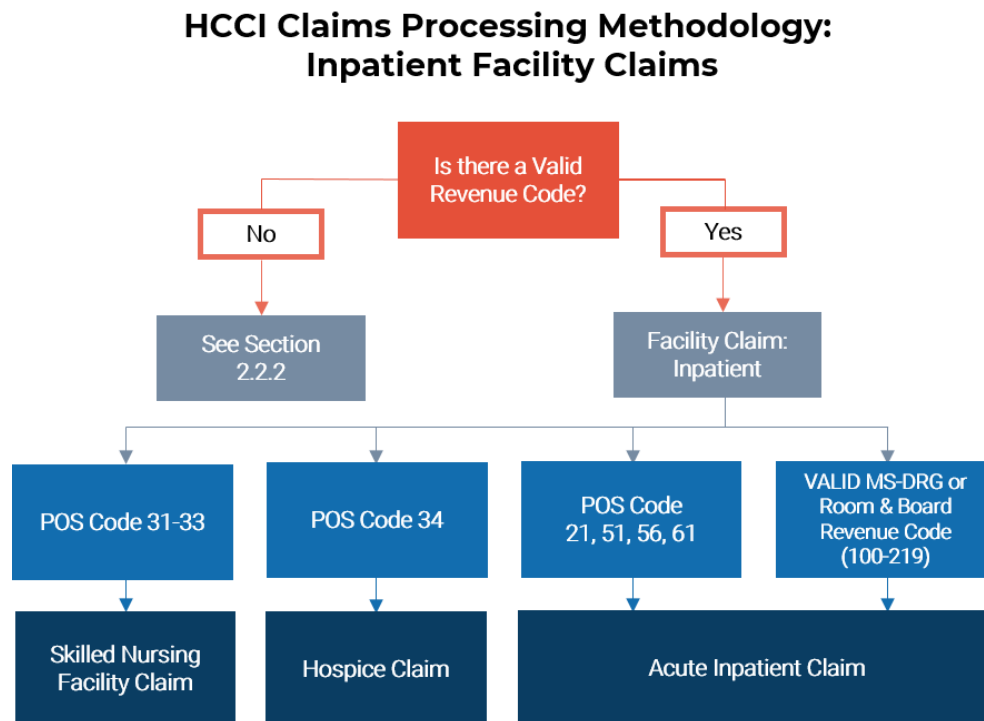
Inpatient facility claims were from hospitals, skilled nursing facilities (SNFs), and hospices, where there was evidence that the insured stayed overnight (Figure 2). The outpatient facility category contained claims that did not include an overnight stay but included observation and emergency room claims (Figure 3). Both outpatient and inpatient claims were for only the facility charges associated with such claims. HCCI classified professional procedural services provided by physicians and nonphysicians according to the industry's commonly used procedure codes (Figure 4), and the claims were grouped into primary care or specialist care. Prescription claims were coded into 30 therapeutic classes and grouped as either generic or brand name prescriptions (Figure 4).

2.2.1 Facility claims

HCCI categorized claims that were billed by place of service as “facility claims.” Medical claims with a valid revenue code (i.e., a code assigned to a medical service or treatment for receiving proper payment) were assumed to be facility claims. Failing that, claims were assumed to be professional procedure claims. Once processed, facility claims were grouped into two major service categories—inpatient and outpatient (Figure 2 and Figure 3).



FIGURE 2: FACILITY CLAIMS PROCESS, INPATIENT



2.2.1.1 Inpatient facility claims

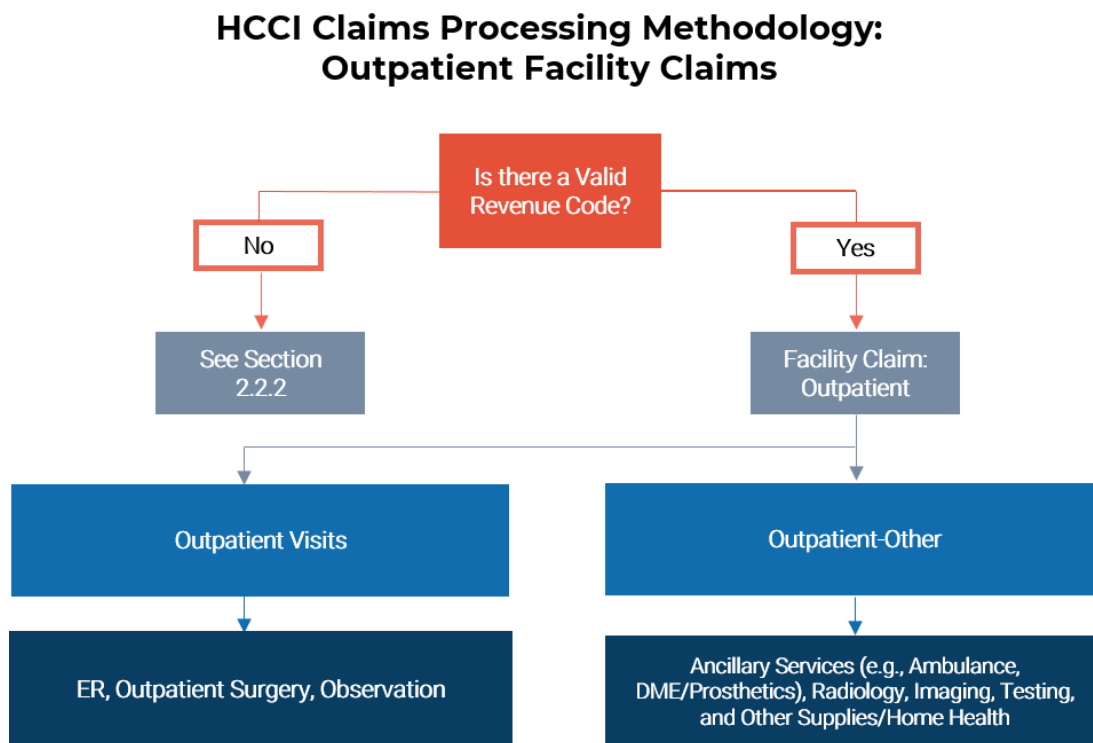
Inpatient services are rendered when patients are kept overnight for treatment but not observation (Figure 2). The inpatient services category included claims with the following criteria: place of service (POS) codes 21, 51, 56, and 61; a valid Medicare Severity Diagnosis-Related Group (MS-DRG) code (V32); or a room and board revenue code of 100-219. This category also included skilled nursing facility (SNF) and hospice claims.

- Inpatient claims were further classified into one of the following four detailed service categories based on the MS-DRG code: medical, surgical, deliveries and newborns, or mental health and substance use (Appendix Table 4.1).
- Inpatient services were also grouped into mutually exclusive MDCs, developed from ICD-9-CM or ICD-10-CM diagnostic codes, as appropriate (Appendix Table 4.2).



- SNF and hospice: SNFs provide nursing and rehabilitation services but with less care intensity than would be received in a hospital. This category was used when the POS code was 31-33.⁴ Hospice is special care provided by a program or facility for the terminally ill. This category was used when the POS code was 34.
- Some inpatient facility claims could not be categorized as described above; these claims were treated as ungroupable. Less than 0.1% of inpatient claims were ungroupable.
- Inpatient claims excluding SNF, hospice, and ungroupable claims were grouped in the subservice category acute inpatient claims.⁵

FIGURE 3: FACILITY CLAIMS PROCESS, OUTPATIENT



2.2.1.2 Outpatient facility claims

Outpatient services are rendered by the sections of a hospital that provides medical



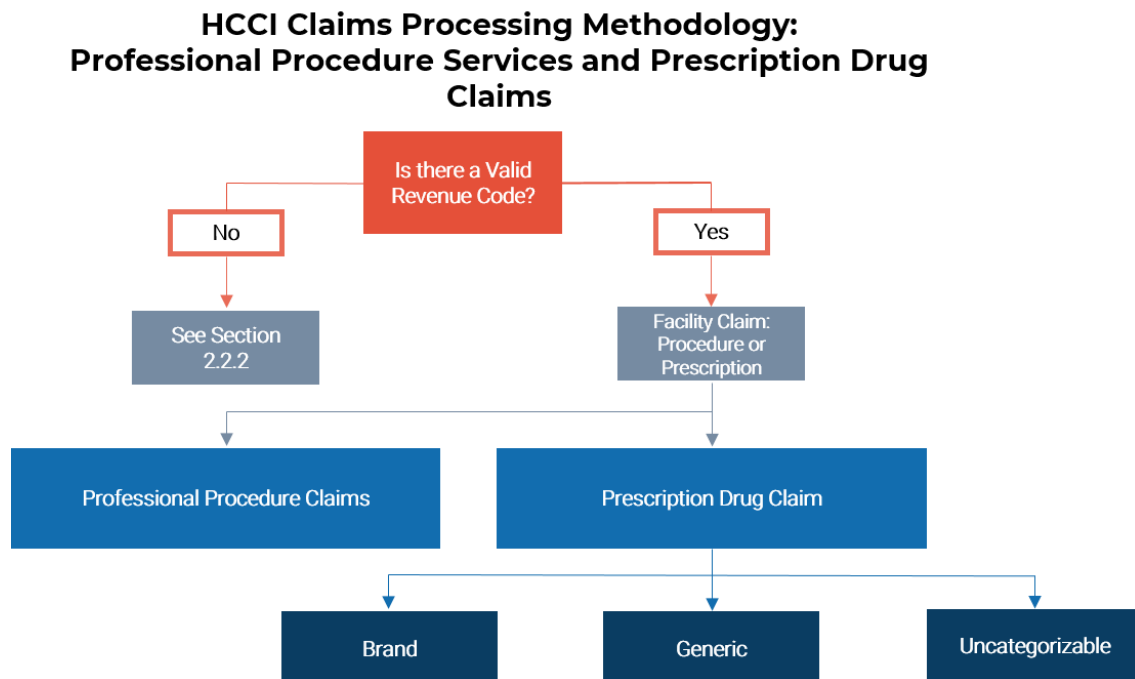
services that do not require an overnight stay or hospitalization (e.g., emergency room [ER], outpatient surgery, observation room). These services can also be provided at freestanding outpatient facilities, including free-standing surgical centers, ambulatory surgical centers (ASCs), and clinics with high-tech diagnostic testing (e.g., MRIs). These outpatient facilities all file Health Care Financing Administration (HCFA) 1500 form with insurers. The outpatient category was used for all facility claims not characterized as inpatient (Figure 3).

- Outpatient claims were classified into subservice categories on the basis of both revenue code and the Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code. Outpatient claims may have multiple services billed on the same claim, so a hierarchy system was used to determine which detail line to use for categorization (Appendix Table 4.3).
- The categories with the highest ranking values were ER, outpatient surgery, and observation. Claims with these services were categorized as the subservice category “outpatient visits”, in which all the detailed records on the claim were grouped together in a single visit and assigned to the detailed service category with the highest hierarchy value (Appendix Table 4.3).
- Outpatient services not categorized as ER, outpatient surgery, or observation were counted as “outpatient-other.” Therefore, each service on the claim was categorized and counted separately.
- Outpatient exceptions: claims without the presence of a revenue code for services with CPT/HCPCS codes for ambulance, home health, and durable medical equipment/prosthetics/supplies were mapped to the outpatient ancillary services category. Hospice procedures given as outpatient services are categorized as outpatient-other claims.



2.2.2 Professional procedure and prescription claims

FIGURE 4: PROFESSIONAL PROCEDURE AND PRESCRIPTION CLAIMS PROCESSES



2.2.2.1 Professional procedure claims

Professional procedure claims are claims filed by a health care professional for medical services provided (Figure 4). Claims with no valid revenue code were assumed to be a professional procedure claim.

Claims were classified into HCCI’s professional procedure detailed categories based on their CPT/HCPCS code (Appendix Table 4.4). Exceptions to the professional procedure codes were all facility-administered drugs (CPT/HCPCS codes J0000–J9999) and were mapped to the administered drugs detailed service category within professional procedures, regardless of whether a revenue code was present on the claim. The professional procedure category also includes facility claims for some independent clinics, such as small private practices, and multi-specialty clinics (e.g., offering primary care and x-rays). Clinics included in the professional procedure category did not file a



HCFA 1500 with insurers.

If information was available, the claim was then also categorized by the provider's specialty (Appendix Table 4.4). Physicians and other professionals were categorized as primary care providers if they were coded as family practice, geriatric medicine, internal medicine, pediatrics, or preventive medicine.

2.2.2.2 Prescription drug claims

As seen in Figure 4, prescription drug and device pharmacy claims were categorized as either brand or generic on the basis of their National Drug Code (NDC). Any drug unidentifiable as either brand or generic was grouped as "uncategorized". These uncategorizable drugs were included in the overall prescription drug trends, but not included as a subservice category of prescriptions. Administered drugs and any devices identified as professional procedures rather than scripts were categorized as professional procedures (Appendix Table 4.4). Prescription claims were grouped into one of the 31 American Hospital Formulary Service (AHFS) therapeutic classes based on the claim's NDC, using the June 2016 First Databank classification system. Prescriptions are then mapped to HCCI's detailed service categories (Appendix Table 4.5). AHFS therapeutic classes are developed and maintained by the American Society of Health-System Pharmacists.⁶ Prescriptions were further classified into sub-detailed classes, based upon their six-digit AHFS class code.

2.3 Chronic conditions categorization

In 2017, HCCI added a new chronic condition flag to the dataset: asthma. The methodologies for the chronic condition groupings are as follows.

2.3.1 Diabetes

HCCI identified individuals with diabetes using codes based on the 2004 Dictionary of Disease Management Terminology (DDMT).⁷ On the advice of chronic condition experts, HCCI relied on the DDMT for categorization rather than the 2013 Healthcare Effectiveness Data and Information Set⁸ specification for comprehensive diabetes care or the Clinical Classifications Software (CCS)⁹ categories for diabetes (Appendix Table 4.6).



HCCI added a diabetes flag to the insured data on the basis of the DDMT methodology. For each year between 2012 and 2016, HCCI flagged insureds as having diabetes mellitus. If there was a diagnosis for (1) two professional services during the year, (2) one or more ER visits, or (3) one or more inpatient admissions was a DDMT diabetes category, the insured was flagged as having diabetes for that year. Once an insured was flagged as having diabetes, he or she was flagged in all subsequent years. HCCI excluded radiology and laboratory claims from the diabetes methodology, as these can be used for screening purposes. In 2016, HCCI updated the diabetes flagging methodology to include the relevant ICD-10-CM codes based on the CMS publication of the code descriptions and the General Equivalence Mappings (GEMs).

2.3.2 Hypertension

HCCI identified individuals with four types of hypertension: essential hypertension on primary diagnosis, essential hypertension on other diagnosis, secondary hypertension on primary diagnosis, and secondary hypertension on other diagnosis. These were identified on the basis of CCS codes for the ICD-9-CM codes and the GEMs for the ICD-10-CM codes (see Appendix Table 4.7). The hypertension flag was added to the HCCI analytic dataset in July 2016. For each year between 2012 and 2016, HCCI reflagged insureds each year as having one of the four identified types of hypertension or as not having hypertension. If there was the presence of one of a relevant ICD-9-CM or ICD-10-CM codes in any of the inpatient, outpatient, or physician settings then the insured was flagged as having hypertension in that year. A hypertension flag for a particular insured could change from year to year.¹⁰

2.4 Grouping and counting methodologies

2.4.1 Unit counting (utilization) methodology

To correctly calculate the utilization count, HCCI analyzed reimbursements for claims. In the following rules, *reimbursement* refers to any monetary payment to a provider, whether a professional procedure provider, facility, or pharmaceutical vendor.



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- If the reimbursement dollars for an admission, visit, or professional procedure were equal to 0, the utilization count was set at 0.
- If the reimbursement dollars for an admission, visit, or professional procedure were less than 0, the utilization count was set at minus 1. Negative reimbursement amounts occur from claim reversals, making it important to reverse the utilization count as well.
- If the reimbursement dollars for an admission, visit, or professional procedure were greater than 0, the utilization count was set at 1.

Service category-specific rules are as follows:

- Inpatient facility: acute, SNF, and hospice
 - If multiple claims had the same patient identification, facility categorization (inpatient, SNF, or hospice), and provider with overlapping or contiguous admission or discharge dates, they were grouped into one admission.
 - The length of stay was determined as the discharge date less the admission date, if that was equal to zero the length of stay is equal to one day. If multiple claims were combined into one admission, the discharge date used was the latest discharge date among all claims; the admission date used was the earliest admission date among all the claims.
- Outpatient facility
 - For ER, outpatient surgery, and observation claims (outpatient visits):
 - a visit was defined as all claims for the same patient, same provider, and same beginning service date;
 - if a claim had multiple beginning service dates among its various detail claim lines, the earliest date was used as the beginning service date for the entire claim.



- For all other outpatient claims, utilization counts were record counts adjusted for the reimbursement dollars (as described above). These are referred to as outpatient-other counts.¹¹

- Professional procedures

For all professional procedure claims, utilization counts were record counts adjusted for the reimbursement dollars and are referred to as professional procedure counts.

- Prescriptions

Prescription drug claims were captured by a filled script. Each prescription was considered a claim, as was every prescription refill; therefore, if a prescription was filled once and then refilled three times, four claims were counted. For the *2015 Health Care Cost and Utilization Report* HCCI calculated utilization through filled days of a prescription, since differing classes of scripts may be for different lengths of time, which could obscure changes in prescription utilization. For example, one month of birth control is 28 filled days, while a round of antibiotics might be 14 filled days.

2.4.2 Intensity weights methodology

In general, intensity reflects the complexity of the service provided or the level of resources required for treatment. HCCI divided price per medical service into two components—intensity-adjusted price and intensity per service. The following section provides details on how intensity weights were assigned by service category. Our methodology bears some resemblance to that employed in Dunn, Liebman, and Shapiro.¹² For the *2016 Health Care Cost and Utilization Report*, HCCI did not implement an intensity-weighting strategy for pharmacy claims.

2.4.2.1 Acute inpatient facility: excluding SNF, hospice, and ungroupable

To weight inpatient facility claims, HCCI excluded SNF, hospice, and ungroupable claims, as these do not have intensity weights. This limited inpatient categorization is referred to as the “acute inpatient”. Each acute inpatient admission was assigned an MS-DRG or



DRG code to which a weight was assigned. The CMS assigns every DRG a weight on the basis of the average costs to Medicare of patients classified in that DRG. The weight reflects the average level of resources expended for the average Medicare patient in that DRG relative to the average level of resources for all Medicare patients. DRGs that are more expensive to treat get a higher weight and vice versa. In this way, DRG weights reflect intensity of treatment. For the *2016 Health Care Cost and Utilization Report* the weights were updated to use the 2016 CMS weights.

2.4.2.2 Outpatient facility

To weight outpatient facility claims, each claim line was mapped to a payment code in the Ambulatory Payment Classification (APC) system based on the CPT/HCPCS code on the claim line. The APC weights used were updated to the 2016 CMS weights.

For claims that could not be mapped to an appropriate APC, weights were assigned on the basis of relative value units (RVUs) for facility procedure codes. RVUs, which are based on the resources required to complete each service, are determined by the American Medical Association and published by the CMS. RVU weights were adjusted as were APC weights, based on the difference between calendar year 2016 RVU conversion factor and calendar year 2016 APC base rate.

2.4.2.3 Professional procedures

Each professional procedure was mapped to a CPT/HCPCS code (Appendix Table 4.4) and was assigned an RVU, either facility or non-facility, on the basis of the place of service. Professional procedures are provided in various settings – hospitals, outpatient facilities, or physician offices. The RVUs were updated to the 2016 weights, as published by the CMS. Commercial adjustments were made to account for professional procedures not commonly seen in Medicare claims and for certain professional procedures such as anesthesia. The commercial modifiers are proprietary; therefore, HCCI cannot publish them.

2.4.3 Methodology for imputing missing weights

For outpatient and professional procedure claim lines that were not assigned weights using the methods described, an analysis was conducted to impute a weight. Weights



were not imputed for inpatient admissions. The imputation analysis followed these key steps:

- Step 1: A detailed service category was determined for each procedure code or revenue code requiring a gap fill (referred to as imputed codes).
- Step 2: The average price paid and average APC/RVU weight for each detailed service category were calculated on the basis of the claims with assigned weights.
- Step 3: Outpatient or professional procedure weight data (as described in section 2.4.2) from the first half of the most recent year and second half of the previous year are combined. This helps account for seasonal changes.
- Step 4: A universal gap fill weight table is created from the Step 1 data.
- Step 5: The gap-filled weights from the table are applied to all payers, for all years.

2.5 Adjustment methodologies

2.5.1 Claims completion methodology

Claims data reflect health care services performed (i.e., claims incurred) in the year noted. Claims generally require time for submission to the payer, processing, and payments to the provider (sometimes called the claim payment lag time, or run-out period).

Completion is a standard actuarial practice designed to allow for the calculation of utilization, prices, expenditures, and intensity of health care services when a full set of claims is not available. Services that have outstanding claims may have a missing or incomplete record. Completion allows for the estimation of the cost impact of the outstanding claims to avoid undercounting or under-projecting trends.

Completion factors varied by type of measure (i.e., dollars, unit counts, and intensity weights) and detailed service category (i.e., subgroups within the service categories). Please see Appendix Tables 4.3, 4.4, and 4.5 for the detailed service category definitions. The factors were based on historical claims payment patterns specific to the HCCI dataset. They were developed using a standard actuarial model for incurred-but-not-paid analysis, as described by Bluhm (Appendix Table 4.7).¹³



For the *2016 Health Care Cost and Utilization Report*, claims incurred from January 1, 2015 through December 31, 2016 and paid through May 31, 2017 (for one payer) and June 30, 2017 (for the other payers) were collected. An adjustment was needed to account for the remaining 2015 and 2016 medical claims that would be paid after May 31 or June 30, 2017. Prescriptions were considered complete and were not adjusted with completion factors. Claims from 2012-2015 were assumed to be fully adjudicated.

2.5.2 Population weighting methodology

For HCCI's estimation process of the total ESI population, the American Community Survey (ACS) was used to establish a distribution of the population covered by commercial health insurance demographic and geographic characteristics (Appendix Table 4.8).¹⁴

To develop demographic and geographic weights, the 5-year averages from the ACS non-public health insurance population survey along with single year ESI population estimates as annual adjustments were used.

Demographic and geographic divisions used were as follows:

- geographic divisions: Core-Based Statistical Area–Metropolitan Statistical Area (CBSA-MSA) and state. Counties that did not map to a CBSA-MSA code – namely, rural counties – were aggregated into a single area by state such that each state had a single “rural area” of counties. Individuals in the dataset may have had more than one state or CBSA listed. This could be due to and insured moving during the year or overlap of CBSAs (e.g., Virginia, Maryland, and the District of Columbia); this affected less than 1 percent of individuals in the dataset;
- age divisions: younger than 6 years of age, 6–17, 18–24, 25–44, and 45–64 (Individuals older than age 64 were excluded); and
- gender divisions.

The distribution of the ESI population for these 4,130 distinct age, gender, and geographic categories was developed and used for all years (Appendix Table 4.9).



**age-gender-geo weight = (ACS population for the age-gender-geo category measured)
/ (ACS national population estimate)**

The HCCI data were also aggregated by geographic division, age division, and gender. This enabled the development of weights using the survey-based targets discussed earlier. The weights were applied to insureds and claims, resulting in representative estimates of the national ESI population younger than age 65.

The HCCI methodology also accounts for the possibility that some individuals will move CBSAs or change age groups within a year. Individuals are grouped into an age-gender-geo group for the proportion of time spent in that group. For example, if an individual lived half of the year in CBSA1 and half of the year in CBSA2, they would be counted as 0.5 of a covered life in each CBSA.

In order to account for yearly population fluctuations, the data were also adjusted using a yearly ACS weighting factor (Appendix Table 4.10).



3. Analysis

The analytic dataset was composed of information on expenditures, prices paid, utilization, and intensity for insureds younger than 65 and covered by ESI. The statistics were weighted by geography-age-gender to be nationally representative. Analyses consisted of summary statistics on spending and the components of spending.

Demographic flags were included for:

- four US census regions (West, Northeast, Midwest, and South);
 - nine US census divisions (New England, Mid-Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, Pacific);
 - 50 states and the District of Columbia;
- five age subgroupings (ages 0–18, 19–25, 26–44, 45–54, and 55–64);
 - four children age subgroupings (ages 0-3, 4-8, 9-13, 14-18); and
- gender.

HCCI divided claims into four service categories: inpatient facility, outpatient facility, professional procedures, and prescriptions. Within those categories were subservice and detailed services:

- five subservice categories (acute inpatient, without skilled nursing facility, hospice, and ungroupable claims; outpatient visits; outpatient-other; generic prescriptions; and brand name prescriptions);
- multiple detailed service categories (e.g., emergency room visits); and
- multiple subdetailed prescription categories based on AHFS prescription classes.

In the *2016 Health Care Cost and Utilization Report Appendix*, HCCI produced report



tables for the service subservice categories, consisting of: annual expenditures per capita, annual out-of-pocket expenditures per capita, utilization per 1,000 insureds, average prices, average intensity, and average intensity-adjusted prices, and expanded these metrics to include gender, geographic, and age group–level statistics. Definitions of terms used in the report can be found in the glossary on the HCCI Website.

3.1 Population membership

Membership in the ESI population is calculated as the total number of months individuals are insured. From this insured-years are calculated by member months divided by 12, to estimate 12 months of coverage or the cost for a year of health care.

3.2 Annual expenditures per capita

HCCI captured per capita health care spending on people with ESI by summing in each year all the weighted dollars directly spent on health care services for filed claims and dividing that amount by the number of insured-years. By this method, the per capita health expenditures in the report estimates the cost per insured, even for insureds who did not use health care services.¹⁵ This metric is a subset of overall national health care spending and may not be comparable to other metrics of national spending because it covers only persons having group ESI and younger than 65 years.

Similar methods were used to calculate expenditures per capita out-of-pocket (the dollars paid by members for health services through copayments, co-insurance, and deductibles) and expenditures per capita by payers.

3.3 Decomposition of expenditures per capita

In the annual *Health Care Cost and Utilization Reports*, estimated health care expenditures were determined by the prices paid to providers for each service and the amount of service (utilization). HCCI decomposed spending trends into a price trend and a utilization trend to determine the major drivers of the health care cost curve.



3.4 Utilization per 1,000 insured

In the annual *Health Care Cost and Utilization Reports*, HCCI calculated utilization rates per 1,000 insureds. The total service count was produced by summing for each service category the admissions, professional procedures, visits, scripts, or filled prescription days. The resulting amount was divided by the number of insured-years. This provided a per-individual utilization count by service category, which was then multiplied by 1,000.

3.5 Average price per service

In the annual *Health Care Cost and Utilization Reports*, HCCI calculated average price per service by dividing total expenditure by total utilization per service or subservice category. By this method, the derived calculation includes the “prices” paid by the payer and the insured out of pocket.

3.6 Decomposition of average prices

HCCI also decomposed prices per service into a complexity of services (intensity) component and an intensity-adjusted price component to help isolate whether price per service increases were driven by intensity of care or rising unit prices. Intensity-adjusted price, or unit price, gives HCCI the average allowed cost per service, deflated by the sum of the weights across all the services in the category, or average price per service weight. Because weights are a measure of how much care is required to treat a patient in a given service category, the sum of the weights is a measure of the total amount, or intensity of care, delivered.

SNF, hospice, and ungroupable inpatient admissions have inconsistent DRG codes, creating difficulty in calculating intensity and intensity-adjusted price for these service categories. Therefore, inpatient facility intensity and intensity-adjusted price trends are reported for the acute inpatient.

Outpatient and professional procedure claims were assigned weights using the relevant APC or RVU codes, as discussed above (see sections 2.4.2 and 2.4.3). After weights were



assigned to outpatient services and professional procedures, HCCI calculated intensity per service.

Using the DRG weights allowed HCCI to measure differences in how much service a typical admission got on the basis of the DRGs in that admission category. Intensity-adjusted prices were calculated for the inpatient, outpatient, and professional procedure service categories. These were not calculated for prescriptions because they were not assigned intensity weights.

3.7 Length of stay

Starting in the *2013 Health Care Cost and Utilization Report*, HCCI added a metric for measuring the length of inpatient admissions in days. The number of days stayed for an admission is calculated as the date of discharge minus the date of admission, if these dates are the same days are equal to one (see section 2.4.1). This method of calculating the number of days is consistent with how health plan benefits are designed and collected. Length of stay for admission categories is then calculated by dividing the total number of days in an inpatient service, subservice, or detailed service category by the utilization of that category. This results in the average length of stay in days for each service, subservice, and detailed service inpatient category.



4. Appendix

4.1 Acute inpatient facility detailed service categories and corresponding MS-DRG codes [V32.0]

Medical	Surgical and Transplant	Labor & Deliveries	Mental Health & Substance Use	Newborns
52-103	1-13	765-768	876	789-793
121-125	14-17	774 & 775	880 - 887	794 & 795
146-159	20-42		894 - 897	
175-208	113-117			
280-316	129-139			
368-395	163-168			
432-446	215-267			
533-566	326-358			
592-607	405-425			
637-645	453-520			
682-700	570-585			
722-730	614-630			
754-761	652-675			
776-782	707-718			
808-816	734-750			
834-849	769 & 770			
862-872	799-804			
913-923	820-830			
933-935	853-858			
945-951	901-909			
963-965	927-929			
974-977	939-941			
	955-959			
	969 & 970			
	981-989			
	998			



4.2 Mapping to MS-DRG codes

MDC	Major Diagnostic Category Description	MS-DRG
1	Nervous system	020–103
2	Eye	113–125
3	Ear, Nose, Mouth, & Throat	129–159
4	Respiratory System	163–208
5	Circulatory System	215–316
6	Digestive System	326–395
7	Hepatobiliary System & Pancreas	405–446
8	Musculoskeletal System & Connective Tissue	453–566
9	Skin, Subcutaneous Tissue, & Breast	570–607
10	Endocrine, Nutritional, & Metabolic System	614–645
11	Kidney & Urinary Tract	652–700
12	Male Reproductive System	707–730
13	Female Reproductive System	734–761
14	Pregnancy; Childbirth	765–782
15	Newborns & Neonates (Perinatal Period)	789–795
16	Blood, Blood-Forming Organs, & Immunological Disorders	799–816
17	Myeloproliferative Diseases & Disorders	820–849
18	Infectious & Parasitic Disease & Disorders	853–872
19	Mental Diseases & Disorders	876–887
20	Alcohol/Drug Use or Induced Mental Disorders	894–897
21	Injuries, Poison, & Toxic Effects of Drugs	901–923
22	Burns	927–935
23	Factors influencing Health Status	939–951
24	Multiple Significant Trauma	955–965
25	Human Immunodeficiency Virus Infections	969 – 977
PR	Transplants	001 – 017
AL	Extensive Procedures Unrelated to Principal Diagnosis	981-989, 998-999



4.3 Outpatient facility service categories mapping to CPT/HCPCS/revenue codes/hierarchies

HCCI Sub-service Category	HCCI Detailed Service Category	Revenue Codes Mapping (standard UB92 codes only)	2014 CPT/HCPCS Codes Mapping (standard 2014 codes)	Hierarchy Ranking
Visits	Emergency Room	450-452; 456; 459	99281-99292; 99466-99476	1
	Outpatient Surgery	360-362; 367; 369; 481; 490; 499; 790; 799	10021-36410; 36420-58999; 60000-69990; 92920-92944; 93501-93581; 0016T-0261T; 0392T-0393T	2
	Observation	760-762; 769	99217-99220	3
Other	Ancillary: Ambulance		A0021-A0999	7
	DME/Prosthetics/ Supplies		A4206-A4652; A5051-A9999; E0100-E8002; K0001-K0902; L0100-L9900	8
	Home Health		99500-99602	9
	Miscellaneous Outpatient Services	420-424; 429-434; 439-444; 449; 480; 482-483; 489; 720- 724; 729- 732; 739; 800-804; 809; 820-	59000-59899; 90832-90899; 90935-90999; 92626-92633; 92950-93352; 93451-93464; 93600-93799; 97001-98943; A4653-A4932; G0008-G0922;	4



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HCCI Sub-service Category	HCCI Detailed Service Category	Revenue Codes Mapping (standard UB92 codes only)	2014 CPT/HCPCS Codes Mapping (standard 2014 codes)	Hierarchy Ranking
		825; 829-835; 839-845; 849-855; 859; 880-882; 889; 900-919; 944-945; 1000-1005	G8006-G9472; H0001-H2037	
Other	Radiology Services	320-324; 329-333; 335, 339, 340-344; 349-352; 359, 400-404; 409, 610-619	70010-70332; 70336; 70350-70390; 70450-70498; 70540-70559; 71010-71130; 71250-71275; 71550-71555; 72010-72120; 72125-72133; 72141-72159; 72170-72190; 72191-72198; 72200-73140; 73200-73206; 73218-73225; 73500-73660; 73700-73706; 73718-73725; 74000-74022; 74150-74178; 74181-74185; 74190-74775; 75557-	5



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HCCI Sub-service Category	HCCI Detailed Service Category	Revenue Codes Mapping (standard UB92 codes only)	2014 CPT/HCPCS Codes Mapping (standard 2014 codes)	Hierarchy Ranking
			75574; 75600-75630; 75635; 75650-76350; 76376-76380; 76390; 76496-76499; 76506-76999; 77001-77003; 77011-77014; 77021-77022; 77031-77063; 77071-77086; 77261-77799; 78000-79999; 96401-96571; R0070-R0076; G6001-G6017	
	Lab/Pathology	300-307; 309-312; 314; 319	36415; 36416; 80047-80440; 80500-80502; 81000-81408; 81410-87999; 88000-88399; 88720-88749; 89049-89240; 89250-89398; P2028-P9615; 0001M-0010M	6



4.4 Professional procedures detailed service categories mapping to CPT/HCPCS codes

HCCI Sub-Detailed Service Category	HCCI Detailed Service Category	CPT/HCPCS Code Range
Administered Drugs, including Chemo Drugs	Administered Drugs	B4164-B5200, C9113-C9257, C9275, C9279, C9285-C9441, C9497, G0260, G0293, G3001, G9017-G9036, J0000-J3520, J3570-J9999; M0075-M0076, M0300, Q0138-Q0181, Q0515, Q2004-Q2028, Q2043, Q2049-Q2050, Q3025-Q3028, Q4074-Q4082, S0012-S0194, S0197, S4989-S5014, S5550-S5553, S5565-S5571
Administration of Drugs	Administration of Drugs	90460-90461, 90471-90474, 96360-96440, 96446-96450, C8957, G0008-G0010, G0259, G8006, G8009, G8012, G8152, G8170, G8219, G8450, G8459, G8461, G8463, G8468, G8473, G8482, G8506, G8579, G8582, G8585, G8598, G8600, G8629, G8630, G8633, G8696, G8702, G8709-G8711, G8799, G8809, G8816, G8859-G8860, G8864, G8868-G8870, G8895, G8916, G8917, G8927, G8935, G8967, G9141, G9189, G9201, G9205, G9206, G9221-G9223, G9245, G9300-G9302, G9315, J3530, J3535, Q0081-Q0085, Q0510-Q0514, S2083, S4981, S5035, S5036, S5497-S5523, S9061, S9325-S9379, S9401, S9430, S9490-S9504, S9537-S9810, T1502-T1503
Allergy	Other	95004-95079, 95115-95199
Anesthesia	Anesthesia	00100-01999, 99100-99140



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HCCI Sub-Detailed Service Category	HCCI Detailed Service Category	CPT/HCPCS Code Range
Cardiovascular	Other	92920-92944, 92950-92979; 92986-92998; 93000-93355, 93451-93583, 93600-93799, 93875-93998, G9157
Consultations	Other	99241-99255
Emergency Room/Critical Care	Other	99281-99292, 99466-99476
Immunizations	Other	90281-90399, 90465-90470, 90476-90749, G9142, Q2034-Q2039, S0195
Inpatient Visits	Other	99217-99239, 99304-99340, 99477-99480
Office Visits	Office Visits	99201-99215, 99341-99350
Ophthalmology	Other	92002-92499, V2020-V2799
Pathology/Lab	Pathology/Lab	80047-89398, P2028-P9615, 0001M-0010M
Physical Medicine	Other	97001-98943
Preventive Visits	Preventive Visits	99381-99397, 99460-99464
Psychiatry & Biofeedback	Other	90785-90911; 0359T-0374T
Radiology	Radiology	70010-79999, A9520, A9575, A9599, R0070-R0076; 0347T-0354T
Surgery	Surgery	10021-69990 excluding 36415-36416, 0016T-0261T, 0308T, 0375T-0377T, 0387T-0393T
Miscellaneous Professional Services	Other	Other codes not listed above



4.5 Prescription detailed service categories matching to AHFS class

AHFS Class	HCCI Detailed Service Category
Antihistamine Drugs	Other
Anti-Infective Agents	Anti-Infective Agents
Antineoplastic Agents	Other
Autonomic Drugs	Other
Blood Derivatives	Other
Blood Formulation, Coagulation, and Thrombosis	Other
Cardiovascular Drugs	Cardiovascular Drugs
Cellular Therapy	Other
Central Nervous System Agents	Central Nervous System Agents
Contraceptives (foams, devices)	Other
Dental Agents	Other
Diagnostic Agents	Other
Disinfectants (for objects other than skin)	Other
Electrolytic, Caloric, and Water Balance	Other
Enzymes	Other
Respiratory Tract Agents	Respiratory Agents
Eye, Ear, Nose, and Throat Preparations	Eye, Ear, Nose, and Throat Preparations
Gastrointestinal Drugs	Gastrointestinal Drugs
Gold Compounds	Other
Heavy Metal Antagonists	Other
Hormones and Synthetic Substitutes	Hormones and Synthetic Substitutes
Local Anesthetics	Other
Oxytocics	Other
Radioactive Agents	Other
Serums, Toxoids, and Vaccines	Vaccines, Serums, and Toxoids
Skin and Mucous Membrane Agents	Skin and Mucous Membrane Agents
Smooth Muscle Relaxants	Other
Vitamins	Other
Miscellaneous Therapeutic Agents	Other
Devices	Other
Pharmaceutical Aids	Other



4.6 Diabetes codes

HCCI used the following codes to identify members with diabetes. The ICD-9-CM Codes were identified according to guidelines set down in the Dictionary of Disease Management Terminology (DDMT). The ICD-10-CM Codes were based on the CMS publication of the code descriptions and the General Equivalence Mappings (GEMs).

Description	ICD-9-CM Codes
Diabetes mellitus	250.xx
Polyneuropathy in diabetes	357.2
Diabetic retinopathy	362.0X
Diabetic cataract	366.41
Insulin pump status	V45.85
Fitting/adjustment of insulin pump, insulin pump titration	V53.91
Encounter for insulin pump training	V65.46
Mechanical complications, due to insulin pump	996.57
Description	ICD-10-CM Codes
Type 1 diabetes mellitus	E10
Type 2 diabetes mellitus	E11
Other specified diabetes mellitus	E13
Presence of insulin pump (external) (internal)	Z96.41
Encounter for fitting and adjustment of insulin pump	Z46.81
Breakdown (mechanical) of insulin pump, initial encounter	T85.614A
Displacement of insulin pump, initial encounter	T85.624A
Leakage of insulin pump, initial encounter	T85.633A
Other mechanical complication of insulin pump, initial encounter	T85.694A
Description	CPT/HCPCS Codes
Diabetic outpatient self-management training services, individual or group	G0108–G0109
Insulin injection, per 5 units	J1815
Destruction of extensive or progressive retinopathy, one or more sessions, cryotherapy, diathermy, photocoagulation	67227–67228



4.7 Hypertension codes

HCCI used the following codes to identify members with hypertension. The ICD-9-CM Codes were identified according to guidelines set down in the Clinical Classifications Software (CCS). The ICD-10-CM Codes were based on the CMS publication of the code descriptions and the General Equivalence Mappings (GEMs).

Description	ICD-9-CM Codes
Essential hypertension	401.1; 401.9
Hypertension with complications and secondary hypertension	401.0; 402.xx; 403.xx; 404.xx; 405.xx; 437.2
Description	ICD-10-CM Codes
Essential hypertension	I10
Hypertension with complications and secondary hypertension	I11; I12; I13; I15; I67.4; N26.2



4.8 Claims completion example

The following is an example of the estimation of incurred but not paid claims. Please note the numbers in this section are for illustration purposes only: They are *not* actual data.

Month	Paid \$ to Date [1]	Completion Factor [2]	Estimated Incurred
Jan-15	\$ 21,675,364	0.998	\$ 21,727,186
Feb-15	\$ 17,339,406	0.996	\$ 17,402,178
Mar-15	\$ 18,271,837	0.999	\$ 18,289,514
Apr-15	\$ 20,286,106	0.997	\$ 20,339,892
May-15	\$ 19,356,580	0.996	\$ 19,426,260
Jun-15	\$ 17,751,856	0.989	\$ 17,945,588
Jul-15	\$ 18,256,838	0.995	\$ 18,355,884
Aug-15	\$ 17,732,384	0.981	\$ 18,083,643
Sep-15	\$ 17,489,161	0.946	\$ 18,481,283
Oct-15	\$ 16,893,933	0.932	\$ 18,120,909
Nov-15	\$ 15,981,513	0.855	\$ 18,681,099
Dec-15	\$ 11,217,486	0.622	\$ 18,028,238
Total	\$ 212,252,463	0.944	\$ 224,881,674

Notes: [1] \$ incurred in the month, paid through 6/30/2016; [2] Completion factors will be developed using a lag triangle method



4.9 Population weighting example

The following is an example of how population adjustment weights were calculated. Please note the numbers in this section are for illustration purposes only. They are *not* actual data.

CBSA-MSA	State	Gender	Age Group	[A]	[B]	[C]=[A]/[B]
				ACS ESI	HCCI ESI	Population Adjustment Weight
Albany, GA Metro Area	GA	Male	1	1,779	508	3.50
Albany, GA Metro Area	GA	Male	2	4,809	1457	3.30
Albany, GA Metro Area	GA	Male	3	2,836	961	2.95
Albany, GA Metro Area	GA	Male	4	7,324	2233	3.28
Albany, GA Metro Area	GA	Male	5	10,134	3001	3.38
Albany, GA Metro Area	GA	Female	1	1,620	459	3.53
Albany, GA Metro Area	GA	Female	2	4,580	1387	3.30
Albany, GA Metro Area	GA	Female	3	3,074	939	3.27
Albany, GA Metro Area	GA	Female	4	9,517	3039	3.13
Albany, GA Metro Area	GA	Female	5	11,723	4048	2.90
Rural (Non-CBSA)	AZ	Male	1	5,514	2,097	2.63
Rural (Non-CBSA)	AZ	Male	2	14,838	4,619	3.21
Rural (Non-CBSA)	AZ	Male	3	6,030	2,593	2.33
Rural (Non-CBSA)	AZ	Male	4	17,573	6,237	2.82
Rural (Non-CBSA)	AZ	Male	5	26,491	7,125	3.72
Rural (Non-CBSA)	AZ	Female	1	5,604	1,919	2.92
Rural (Non-CBSA)	AZ	Female	2	14,473	4,384	3.30
Rural (Non-CBSA)	AZ	Female	3	5,621	2,442	2.30
Rural (Non-CBSA)	AZ	Female	4	20,293	5,808	3.49
Rural (Non-CBSA)	AZ	Female	5	29,819	7,369	4.05



4.10 Population weighting annual adjustment factors

Year	Annual ACS ESI Population	Annual Population Adjustment Factor
2012	153,257,059	1.0016
2013	152,888,235	0.9992
2014	154,990,164	1.0130
2015	154,990,164	1.0130



5. Notes

¹ Congressional Research Service. Private Health Insurance Premiums and Rate Reviews [Internet]. Washington (DC): CRS; 2011 Jan [cited 2012 May 11]. Available from: http://assets.opencrs.com/rpts/R41588_20110111.pdf.

² American Academy of Actuaries. Critical Issues in Health Reform: Premium Setting in the Individual Market [Internet]. Washington (DC): AAA; 2010 March [cited 2012 May 11]. Available from: http://www.actuary.org/pdf/health/premiums_mar10.pdf.

³ Congressional Budget Office. Key Issues in Analyzing Major Health Insurance Proposals, Chapter 3, Factors Affecting Insurance Premiums [Internet]. Washington (DC): CBO; 2008 December [cited 2012 May 11]. Available from: <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9924/12-18-keyissues.pdf>. For additional information on insurers' administrative costs and profits, see Centers for Medicare & Medicaid Services. National Health Expenditure Accounts: tables 2010 [Internet]. Baltimore (MD): CMS; 2012 Jan [cited 2012 May 11]. Available from: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>.

⁴ Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual: Chapter 26: Completing and Processing Form CMS-1500 Data Set [Internet]. Baltimore (MD): CMS; 2011 Dec [cited 2012 May 18]. Available from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf>.



⁵ In the *2013 Health Care Cost and Utilization Report* and *2014 Health Care Cost and Utilization Report*, this subservice category is called “acute inpatient”. In the *2012 Health Care Cost and Utilization Report* and the *Children’s Health Spending Report: 2008–2012* this subservice category was called “inpatient subset”. In the *Health Care Cost and Utilization Report: 2011*, this was labeled “inpatient without SNF”.

⁶ McEvoy, Gerald K., ed. *AHFS Drug Information 2010*. Bethesda, MD: American Society of Health-System Pharmacists, 2010. Print.

⁷ Duncan, I.G., ed. *Dictionary of Disease Management Terminology*. Washington, DC: Disease Management Association of America, 2004.

⁸ Health Plan Employer Data and Information Set (HEDIS), Washington, DC: National Committee for Quality Assurance, 2013.

⁹ Clinical Classifications Software (ICD-9-CM) Summary and Download – Redirect. Agency for Healthcare Research and Quality, Rockville, MD: 2012 Dec. Available from: <http://www.ahrq.gov/research/data/hcup/ccs.html>.

¹⁰ The hypertension flag is new to the HCCI benchmarking effort of chronic conditions categories. The efficacy of our methodology is still being explored. HCCI welcomes feedback from area experts.

¹¹ These are referred to as “outpatient other” counts in *2014 Health Care Cost and Utilization Report*, *2013 Health Care Cost and Utilization Report*, *2012 Health Care Cost and Utilization Report*, *Health Care Cost and Utilization Report: 2011* and as “outpatient procedure” counts in *Health Care Cost and Utilization Report: 2010*.



¹² Dunn, Abe, Eli Liebman, and Adam Hale Shapiro. "Developing a Framework for Decomposing Medical-Care Expenditure Growth: Exploring Issues of Representativeness." *Measuring Economic Sustainability and Progress*. 2012.

¹³ Bluhm, W. F., ed. *Group Insurance*. 4th ed. Winsted: ACTEX Publications, Inc; 2003. P. 811-27. The specific methodology is proprietary and not owned by HCCI.

¹⁴ U.S. Department of Commerce. U.S. Census Bureau. American Community Survey Office. Data and Documentation [Internet]. Washington (DC): Census; 2010 March [cited 2012 May 11]. Available from:
http://www.census.gov/acs/www/data_documentation/data_main.

¹⁵ To calculate total prices paid for total expenditures per capita, the insured (co-payments, coinsurance, and deductibles) and payer expenditures per capita are summed. For facility and professional procedure claims, prices paid are calculated for all members who have medical insurance. For prescription claims, prices paid are calculated for all members with medical and prescription insurance.