

FINAL BILL REPORT

ESSB 5084

C 246 L 15
Synopsis as Enacted

Brief Description: Modifying the all payer claims database to improve health care quality and cost transparency by changing provisions related to definitions regarding data, reporting and pricing of products, responsibilities of the office of financial management and the lead organization, submission to the database, and parameters for release of information.

Sponsors: Senate Committee on Health Care (originally sponsored by Senators Becker, Frockt, Conway, Keiser and Mullet; by request of Governor Inslee).

Senate Committee on Health Care
House Committee on Health Care & Wellness

Background: The 2014 Legislature passed E2SHB 2572 which directed the Office of Financial Management (OFM) to establish a statewide all-payer health care claims database to support transparent public reporting of health care information. OFM must select a lead organization to coordinate and manage the database. The lead organization is responsible for collecting claims data, designing data collection mechanisms, ensuring protection of the data, providing reports from the database, developing protocols and policies, developing a plan for financial sustainability and charge fees not to exceed \$5,000 for reports and data files, and convening advisory committees. OFM initiated rulemaking but delayed selection of a lead organization.

Claims data includes the claims data related to health care coverage for Medicaid and the Public Employees Benefits Board program, and other voluntarily provided data that may be provided by insurance carriers and self-funded employers. The claims data provided to the database, the database itself, and any raw data received from the database are not public records and are exempt from public disclosure.

Extensive stakeholder discussions were held over the 2014 interim to identify modifications for submission of claims data, protection of proprietary financial data, and additional parameters for the release of data and reports.

Summary: OFM must initiate a competitive procurement process to select a lead organization to coordinate and manage the all-payer claims database. The proposal must include criteria to be applied in the scoring evaluation that include extra points for the following items: the degree of experience in health care data collection, analysis, analytics, and security; a long-term self-sustainable financial model; experience in convening and

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engaging stakeholders to develop reports; experience meeting budget and timelines for report generations; and the ability to combine cost and quality data. The successful lead organization must apply to be certified as a qualified entity by the Centers for Medicare and Medicaid Services by December 31, 2017.

As part of the procurement process, the lead organization must demonstrate they have a contract with a data vendor to perform data collection, processing, aggregation, extracts, and analytics. The data vendor must establish a secure data submission process, review data files, ensure quality of data files, assign unique identifiers to individuals represented in the database, demonstrate internal controls and state of the art encryption methods, store data on a secure server, and ensure state of the art security for transferring data. The lead organization and data vendor must provide a detailed description of the security methods to the Office of the Chief Information Officer housed within OFM.

The following data suppliers must provide claims data: the Medicaid program, the Public Employees Benefits Board program, all health insurance carriers operating in this state, all third-party administrators paying claims on behalf of health plans in this state, and the state Labor and Industries program. The Director of OFM may expand this requirement to include other types of insurance policies, such as Long-Term Care policies and Medicare supplemental coverage. Employer-sponsored self-funded health plans and Taft-Hartley trusts may voluntarily provide claims data.

The lead organization must develop a plan for the financial sustainability of the database as self-sustaining. The \$5,000 cap on the fees the lead organization may charge for reports and data files is removed. Any fees must be approved by OFM and should be comparable, accounting for relevant differences across data requests and uses. Fees must not be charged to providers or data suppliers other than the fees directly related to requested reports.

The advisory committees the lead organization must convene are modified to include in-state representation from key provider organizations, hospitals, public health, health maintenance organizations, large and small private purchasers, consumer organizations, and the two largest carriers supplying claims data.

Requests for claims data must include the following: the identity of any entities that will analyze the data; the stated purpose of the request; a description of the proposed methodology; the specific variable requested; how the requester will ensure all data is handled to ensure privacy and confidentiality protection; the method for storing, destroying, or returning the data to the lead organization; and protections that will ensure the data is not used for any purposes not authorized by the approved application. Any entity that receives claims or other data must maintain confidentiality and may only release data if it does not contain proprietary financial information or direct or indirect patient identifiers, and the release is described and approved as part of the request.

The lead organization, in conjunction with OFM and the data vendor, must create a process to govern levels of access to the data:

- Claims data that include proprietary financial information, direct patient identifiers, indirect patient identifiers, unique identifiers, or any combination, may be released only to researchers with a signed data use and confidentiality agreement. Access to

this level of data is removed for federal, state and local government agencies, and for the lead organization;

- Claims data that do not contain direct patient identifiers, but may contain proprietary financial information, indirect patient identifiers, unique identifiers, or any combination, may be released to agencies, researchers, the lead organization, and other entities with a signed data use agreement, however agencies may not use the data for procurement of health benefits for their employees; and
- Claims data that do not contain proprietary financial information or direct patient identifiers may be released upon receipt of a signed data use agreement.

Reports may not contain proprietary financial information, or direct or indirect patient identifiers; however, the use of geographic areas with sufficient population size or aggregate gender, age, medical condition, or other characteristics may be used for reports as long as they cannot lead to the identification of an individual. Reports issued by the lead organization may utilize proprietary financial information to calculate aggregate cost data. OFM must develop in rule a format for the calculation and display of aggregate cost data. In developing the rule, OFM must solicit feedback from stakeholders and must consider data presented as proportions, ranges, averages, and medians, as well as the differences in types of data.

Recipients of data must protect data containing direct and indirect identifiers, proprietary financial information, or any combination thereof; must not re-disclose the data; attempt to determine the identify of any person whose information is included in the data set; consent to penalties associated with the inappropriate disclosures or uses of the data; and destroy or return the data at the conclusion of the data use agreement.

By October 31 of each year, the lead organization must submit a list to OFM of reports they anticipate producing during the following calendar year. OFM may establish a public comment period not to exceed 30 days and must submit the list and any comments to the appropriate committees of the Legislature for review. The lead organization may not publish any report that directly or indirectly identifies individual patients; disclose a carrier's proprietary financial information, or compare performance that includes any provider with fewer than four providers, rather than five. The lead organization may not release a report that compares providers, hospitals, or data suppliers unless it allows verification of the data and comment on the reasonableness of conclusions reached. The requirement to limit reports where one data supplier comprises more than 25 percent of the claims data is removed. The lead organization must distinguish in advance when it is operating as the lead organization and when it is operating in its capacity as a private entity. The claims data that contain direct patient identifiers or proprietary financial information must remain exclusively in the custody of the data vendor and may not be accessed by the lead organization.

OFM must adopt rules, including procedures for establishing appropriate fees, procedures for data release, and penalties associated with the inappropriate disclosures or uses of direct patient identifiers, indirect patient identifiers, and proprietary financial information.

By December 1, 2016 and 2017, OFM must report to the Legislature on the development of the database including, but not limited to, budget and cost detail, technical progress, and work plan metrics. Two years after the first report is issued, OFM must report to the Legislature every two years regarding the cost, performance, and effectiveness of the

database, and the performance of the lead organization. Using independent economic expertise, subject to appropriation, the report must evaluate whether the database advanced the goals established for the database, as well as the performance of the lead organization. The report must make recommendations on how the database can be improved, whether the contract for the lead organization should be modified, renewed, or terminated, and the impact the database had on competition between and among providers, purchasers, and payers.

The act contains a severability clause in the event any portion of the act is determined to be invalid.

Votes on Final Passage:

Senate	44	5	
House	82	15	(House amended)
Senate	41	6	(Senate concurred)

Effective: July 24, 2015