

SENATE BILL REPORT

SB 5537

As of February 18, 2013

Title: An act relating to improving the quality and value of health care with greater transparency of price and quality data.

Brief Description: Improving the quality and value of health care with greater transparency of price and quality data.

Sponsors: Senators Keiser, Schlicher, Frockt, Shin, Mullet, Rolfes, Murray, Kline and Conway.

Brief History:

Committee Activity: Health Care: 2/14/13.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: Some purchaser groups, like Catalyst for Payment Reform and the Pacific Business Group on Health, are promoting tools that expand the transparency in health care costs and provide purchasers and consumers more information to manage their health care purchasing. Some pricing information is effectively blocked from purchasers and consumers by contract restrictions between health insurance plans and providers.

The Office of the Insurance Commissioner (OIC) makes use of statistical reporting agents for sensitive data required in other lines of business, but does not currently use a statistical reporting agent for health care data. A statistical reporting agent could offer functionality similar to an all-payer claims data base.

Summary of Bill: All health care insuring entities must submit price and quality data to OIC and to large group purchasers, that includes information for each provider and facility. Health insuring entity means any party that is legally responsible for payment of a claim for a health care service, including insurance carriers, an employer or self-insured plan, a pharmacy benefit manager, and a third-party administrator. Contracts between health insuring entities and providers or facilities must include a requirement that allows price and quality information to be released to OIC or to the purchasers of the group coverage.

OIC must adopt rules to clarify the required data and format for reporting and the data must include at a minimum: health care claims and enrollment data, paid health claims data, and

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data related to costs, prices, quality, and utilization. OIC must establish criteria and procedures for the development of limited use data sets, and criteria to ensure that limited use data sets are accessible and compliant with federal and state privacy laws. The collection, storage, and release of health care data is subject to the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA).

OIC may choose to designate a health plan statistical agent responsible for the collection, auditing, preparation, and reporting of the health care data. A health plan statistical agent means an entity designated to collect health care-related data from insuring entities and to report the data to OIC.

OIC may impose a civil penalty on a health insuring entity that fails to report the required data. OIC must adopt a schedule of penalties not to exceed \$500 per day per violation. The civil penalties may be remitted or mitigated if terms and conditions are consistent with public health and safety.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This is a way to give a voice to purchasers and to help them know what they are truly paying for. It creates a critical mass of customer information to help change the way we purchase and change health care. The concerns with sharing the data are not insurmountable. There is value in transparency and in addressing the barriers to transparency. Consumers and employers are concerned and remain in the dark about the cost drivers in health care. We need to move more swiftly than the Puget Sound Health Alliance effort has been moving.

CON: We have significant concerns with sharing proprietary data and allowing the data to fall into the public domain. OIC uses statistical agents for some business today but they gather aggregated data and prepare summary data for the regulators; this is more like an all-payer claims database. We are excited about the potential to have transparency in data for providers and we have interest in a functional database, but we remain committed to the Puget Sound Health Alliance voluntary effort to build a database. They are in the best place to explore the concerns with data sharing, placing protections on the data, and establishing standards for use of the data. We support transparency efforts and remain committed to the efforts underway. This strikes us as an all-payer claims database construct that is very complicated. It is important to first clarify the goal of what the database will provide and how it will be accessed for cost and quality information. We already provide cost and quality information to our purchasers, and the self-funded clients have all of it now. We are concerned this is premature and we remain interested in the Puget Sound Health Alliance voluntary system. Their model can become the model for the state and we can build on that after we decide who can use the data and how we reflect quality indicators.

Persons Testifying: PRO: Senator Keiser, prime sponsor; Patrick Connor, National Federation of Independent Business.

CON: Mel Sorensen, America's Health Insurance Plans; Katie Kolan, WA State Medical Assn.; Chris Bandoli, Regence Blue Shield; Len Sorrin, Premera Blue Cross; Cassie Sauer, WA State Hospital Assn.