

HOUSE BILL REPORT

HB 1437

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to 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.

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: Representatives Cody, Harris, DeBolt, Johnson, Jinkins, Wilcox, Van De Wege, Stokesbary, Riccelli, Tharinger, Moeller, Kagi, Gregerson, Fitzgibbon and Ormsby; by request of Governor Inslee.

Brief History:

Committee Activity:

Health Care & Wellness: 1/30/15, 2/3/15 [DP];
Appropriations: 2/18/15, 2/25/15 [DP].

Brief Summary of Bill

- Requires the Office of Financial Management to use a competitive process to select a lead organization to coordinate and manage the all-payer health claims database, and modifies requirements applicable to the lead organization.
- Requires all health carriers, in addition to the state Medicaid program and Public Employees' Benefits Board programs, to submit claims data to the database.
- Modifies standards for reports and release of claims data based on whether the data contain proprietary financial information or direct or indirect patient identifiers.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 12 members: Representatives Cody, Chair; Riccelli, Vice Chair; Harris, Assistant Ranking Minority Member; Clibborn, DeBolt, Jinkins, Johnson, Moeller, Robinson, Rodne, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 3 members: Representatives Schmick, Ranking Minority Member; Caldier and Short.

Staff: Alexa Silver (786-7190).

Background:

Engrossed Second Substitute House Bill 2572, enacted in the 2014 legislative session, required the Office of Financial Management (Office) to establish a statewide all-payer health care claims database. The goals of the database are to improve transparency to: assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to benchmark their performance; enable purchasers to identify value, build expectations into their purchasing strategies, and reward improvements over time; and promote competition based on quality and cost.

Lead Organization.

The Director of the Office (Director) is required to select a lead organization to coordinate and manage the database, and the lead organization is responsible for collecting claims data and reporting performance on cost and quality. At the direction of the Office, the lead organization must, among other things: design collection mechanisms with consideration for time, cost, and benefits; ensure protection of collected data; make information from the database available as a resource; develop policies to ensure quality of data releases; develop a plan for financial sustainability and charge fees up to \$5,000 (unless otherwise negotiated), with any fees comparable across requests and users and approved by the Office; and appoint advisory committees on data policy and the data release process.

The Office initiated rulemaking in July 2014, but delayed selection of a lead organization.

Submissions to the Database.

Data suppliers must submit claims data to the database within the time frames established by the Director and in accordance with procedures established by the lead organization. "Claims data" include: (1) claims data related to health care coverage and services funded in the operating budget for Medicaid programs and the Public Employees Benefits Board program; and (2) claims data voluntarily provided by other data suppliers, including carriers and self-funded employers. An entity that is not a data supplier but that chooses to participate in the database must require any third-party administrator to release any claims data related to persons receiving health coverage from the entity's plan. Data suppliers must submit an annual status report to the Office regarding their compliance.

Confidentiality and Release of Claims Data.

The Office must direct the lead organization to maintain the confidentiality of the data it collects that include direct or indirect patient identifiers. Any person who receives data with patient identifiers must also maintain confidentiality and may not release the information. Data with direct or indirect patient identifiers, as specifically defined in rule, may be released to: (1) federal, state, and local government agencies upon receipt of a signed data use agreement; and (2) researchers with approval of an institutional review board upon receipt of a signed confidentiality agreement. Data with indirect patient identifiers may be released to an agency, researcher, and other person upon receipt of a signed data use agreement. Data that do not contain direct or indirect patient identifiers may be released upon request. "Direct patient identifier" means information that identifies a patient, and "indirect patient identifier" means information that may identify a patient when combined with other information.

Recipients of data with patient identifiers must agree in a data use agreement and confidentiality agreement to take steps to protect patient identifying information and not re-disclose the data except as authorized in the agreement or as otherwise required by law. Recipients of data may not attempt to determine patients' identity or use the data in a manner that identifies the individuals or their families.

Data obtained through activities related to the database are not subject to subpoena, and a person with access to the data may not be compelled to testify.

Reports by the Lead Organization.

Under the supervision of the Office, the lead organization must use statewide performance measures and the database to prepare health care data reports. Prior to releasing reports that use claims data, the lead organization must submit the reports to the Office for review and approval. Comparisons of costs among systems must account for differences, including acuity of patients.

The lead organization may not publish data or reports that directly or indirectly identify patients or disclose specific reimbursement arrangements between a provider and a payer. In addition, the lead organization may not compare performance in a report generated for the general public that includes any provider in a practice with fewer than five providers. The lead organization may not release a report comparing or identifying providers, hospitals, or data suppliers unless it allows them to verify the accuracy of the information and submit corrections within 45 days and unless it corrects errors. The lead organization must ensure that no individual carrier or self-insured employer using the carrier's provider contracts comprises more than 25 percent of the claims data used in any report or other analysis generated from the database.

Summary of Bill:

Lead Organization.

Starting no later than July 1, 2015, the Director of the Office of Financial Management (Office) must use a competitive process to select a lead organization to coordinate and manage the all-payer health care claims database. The organization must be composed of health care purchasers, state licensed insurers, union trusts, providers, and consumers. The Office must use a competitive procurement process, including a request for information prior to issuing a request for proposal. All documents must be posted on the Office website.

The requirements for the lead organization are modified. It must:

- design data collection mechanisms considering the time and cost incurred by data suppliers and others in submission;
- store data with proprietary financial information in compliance with the bill;
- develop protocols and policies, including pre-release peer review by data suppliers, to ensure the quality of data releases and reports;
- charge fees that are comparable, accounting for relevant differences across requests and uses; and
- ensure that advisory committees include in-state representation from stakeholders, including large and small private purchasers and the two largest carriers supplying claims data.

The \$5,000 cap on the lead organization's fees is eliminated. The Office must adopt procedures for establishing appropriate fees.

Submissions to the Database.

The state Medicaid program, Public Employees' Benefits Board programs, and all health carriers operating in the state must submit their claims data to the database. The Director may expand this requirement to include other types of insurance policies, such as long-term care insurance policies. Employer-sponsored self-funded plans and Taft-Hartley trusts may voluntarily provide claims data. Any data suppliers used by an entity that voluntarily participates in the database must provide claims data to the lead organization upon the entity's request. The lead organization (instead of each data supplier) must submit an annual status report to the Office regarding compliance with these requirements.

"Claims data" means the data required to be submitted, including billed, allowed, and paid amounts, and additional information defined in rule. "Data supplier" means a carrier that provides claims data and a carrier, third-party administrator, or other entity that provides data at the request of an employer-sponsored self-funded plan or Taft-Hartley trust.

Release of Claims Data.

Requests for claims data must include the following information:

- the identity of the entities that will analyze the data;
- the purpose of the request and an explanation of how it supports the goals of the law governing the database;
- the proposed methodology;
- the specific variables requested and an explanation of how the data are necessary to achieve the stated purpose;

- how the requester will ensure the data are handled in accordance with required privacy and confidentiality protections;
- the method by which the data will be stored, destroyed, or returned to the lead organization; and
- the protections that will be used to keep the data from being used for unauthorized purposes.

The lead organization may deny a request for data if the request does not include the required information or meet criteria established by the lead organization's advisory committee or for reasons established by rule.

In conjunction with the Office, the lead organization must develop a process to govern levels of access to and use of data. Data that include proprietary financial information or direct patient identifiers may be released only to the extent necessary to achieve the goals of the all-payer health care claims database, as follows:

- to government agencies on receipt of a signed data use and confidentiality agreement. Government agencies may not use the data in the purchase or procurement of health benefits for their employees;
- to researchers with approval of an institutional review board on receipt of a signed data use and confidentiality agreement. A researcher or research organization must agree not to disclose the data to any other party, including affiliated entities; and
- to any entity when functioning as the lead entity.

Data that contain indirect patient identifiers but do not contain proprietary financial information or direct patient identifiers may be released to entities approved by the lead organization. Data that do not contain direct or indirect patient identifiers or proprietary financial information may be released upon request.

The lead organization must distinguish in advance to the Office when it is operating as the lead organization versus when it is operating as a private entity. When acting as a private entity, its access to data is governed by the same process as other requesters.

Confidentiality.

The Office must direct the lead organization to maintain the confidentiality of data that include proprietary financial information, in addition to direct or indirect patient identifiers. Any entity that receives data must also maintain confidentiality and may only release the data if: (1) it does not contain proprietary financial information or direct or indirect patient identifiers; and (2) the release is approved as part of the data request. A "direct patient identifier" is a data variable that directly identifies an individual, and an "indirect patient identifier" is a data variable that may identify an individual when combined with other information. "Proprietary financial information" means claims data or reports that disclose or would allow the determination of specific terms of contracts, discounts, or fixed reimbursement arrangements or other specific reimbursement arrangements between a facility or provider and a payer, or internal fee schedule or other internal pricing mechanism of integrated delivery systems owned by a carrier.

Recipients of data must agree in a data use or confidentiality agreement to:

- take steps to protect data containing direct or indirect patient identifiers or proprietary financial information;
- not redisclose the claims data, unless it does not contain proprietary financial information or direct or indirect patient identifiers and the release is approved as part of the data request;
- not attempt to determine the identity of a person whose data is included in the data set or use the claims or other data in a manner that identifies an individual or family; and
- store, destroy, or return claims data at the conclusion of the agreement.

Reports using data obtained through this process may not contain proprietary financial information or direct or indirect patient identifiers. Reports issued by the lead organization may use proprietary financial information to calculate aggregate cost data to be displayed in the report. The Office must approve a format for calculating and displaying aggregate cost data to prevent the disclosure or determination of proprietary financial information. In developing the format, the Office must solicit feedback from stakeholders and consider data presented as proportions, ranges, averages, and medians, as well as the differences in types of data gathered and submitted.

Data that are distributed or reported through activities related to the database (in addition to data that are obtained through such activities) are not subject to subpoena, and a person with access to the data may not be compelled to provide such information pursuant to subpoena.

Reports by the Lead Organization.

Through the contract with the Office (in addition to being under the Office's supervision), the lead organization must prepare reports using the database and the statewide performance and quality measure set. Prior to release, the lead organization must submit reports to the Office for review (but not approval). By October 31 of each year, the lead organization must submit to the Office a list of reports it anticipates producing during the following year. The Director may establish a public comment period and must submit the list and any comments to the Legislature for review.

Reports that use claims data prepared by the lead organization for the Legislature and the public should promote awareness and transparency in the health care market. The features of such reports are modified to include comparisons of costs among providers and systems that account for differences in the case mix and severity of illness of patients and populations.

The lead organization's published data and reports may not: (1) disclose a carrier's proprietary financial information; or (2) compare performance in a report for the general public that includes any provider in a practice with fewer than four providers (rather than five). The lead organization may not release a report comparing and identifying providers, hospitals, or data suppliers unless it allows the provider, hospital, or data supplier to comment on the reasonableness of conclusions reached and submit corrections within 30 days (rather than 45 days).

The requirement that no individual data supplier comprise more than 25 percent of the data used in any report is eliminated.

Reports to the Legislature.

By December 1, 2016 and 2017, the Office must report to the Legislature regarding the development and implementation of the database, including budget and cost detail, technical progress, and work plan metrics. Following the year in which the first report is issued or the first release is provided from the database, the Office must report to the Legislature every two years on the cost, performance, and effectiveness of the database and the performance of the lead organization. The report must use independent economic expertise, subject to appropriation, to evaluate the lead organization's performance and whether the database has advanced its stated goals. The report must also make recommendations on: (1) how the database could be improved; (2) whether the contract with the lead organization should be modified, renewed, or terminated; and (3) the impact the database has had on competition.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill addresses issues that were unresolved last year, such as how data are released and how proprietary information is protected. Many stakeholders worked hard over the interim to create this bill. The all-payer claims database will support greater transparency on cost and quality throughout the health care system. The more transparency tools that are available, the more likely it is that meaningful solutions will be developed. The bill strikes a balance between making sure that there is access to cost and quality data while also protecting privacy and confidential information from being used in a competitive way in the marketplace. There is no concern about removing the 25 percent provision, because new provisions in this bill address those issues.

This bill is a priority for small business. The Affordable Care Act requires everyone to purchase insurance, but small business owners struggle to provide it for employees because costs just go up. The all-payer claims database is one of the only pro-consumer, pro-business, free market solutions offered this year to bring down the cost curve. Cost information will be paired with quality to bring real information to consumers so they can make better informed purchasing decisions.

There are huge variations in the cost of procedures, and it is impossible to know what a procedure will cost at one place or another. Physicians are unable to tell which hospitals cost the most or least and where quality is the highest. There is good data available on inpatient care, which is used to improve quality in hospitals, but there is no good information on outpatient care. The goal is to use the data in the all-payer claims database for better delivery of care.

The Washington Health Alliance has operated a voluntary all-payer claims database for eight years, so there is an established infrastructure that paves the way for the bill. The data presented by the Washington Health Alliance are fair-minded and balanced, and protections are taken for consumers and providers. This bill is a good step forward, but does not go far enough.

The database will be a valuable resource for evidence-based care, improving, for example, our understanding of cancer care outcomes and costs. The bill should be amended so that the requirements for data release are not duplicative of the institutional review board application.

(In support with concerns) The bill makes the all-payer claims database more workable, but concerns about financing remain. The lead organization will be responsible for funding the database with the sale of data, but there is concern about eventual financial liabilities to the state budget. There is a hope that the database can be implemented with grant monies that have been received and that it will eventually support itself.

(Opposed) None.

Persons Testifying: (In support) Representative Cody, prime sponsor; Bob Crittenden, Office of the Governor; Len Sorrin, Premera Blue Cross; Chris Bandoli, Regence Blue Shield; Nancy Giunto, Washington Health Alliance; Nick Rajacich, Washington State Medical Association; Lisa Thatcher, Washington State Hospital Association; Patrick Connor, National Federation of Independent Business; Sydney Smith Zvara, Association of Healthcare Plans; and Scott Ramsey, Fred Hutchinson Cancer Center.

(In support with concerns) Sheri Nelson, Association of Washington Business.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass. Signed by 27 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Parker, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Carlyle, Cody, Dent, Dunshee, Fagan, Haler, Hansen, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, MacEwen, Magendanz, Pettigrew, Sawyer, Senn, Springer, Stokesbary, Sullivan, Tharinger, Van Werven and Walkinshaw.

Minority Report: Do not pass. Signed by 6 members: Representatives Chandler, Ranking Minority Member; Buys, Condotta, G. Hunt, Schmick and Taylor.

Staff: Erik Cornellier (786-7116).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

No new changes were recommended.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill builds on House Bill 2572 from last year. The things that changed are fairly marginal in terms of expenses, but the impacts on the database are huge. The bill brings in all payers while making sure the database maintains confidentiality. The costs are minimal and the fiscal risks to the state are small. There are establishment grants and innovation grants that can support this work.

Last year the Legislature approved the All Payer Claims Database (APCD). State agencies have received money to implement it, but the database will not work in its current form. It only covers the Public Employees Benefits Board (PEBB) and Medicaid, and no one payer can make up 25 percent of the data for a report. The APCD cannot produce useful reports, and implementing it in its current form would squander taxpayer money on a database that would fail. That is fiscally irresponsible.

The APCD could save state and local governments money by allowing them to make more informed health care decisions. Effective use of cost and quality metrics would allow public and private sector employers to design plans that would improve health and reduce costs. Patients would have access to meaningful cost and quality data that would help them make good choices. These are free market solutions to health care issues that people are facing.

King County, the largest local employer in Washington, faces the same challenges with health care costs as state and private employers. Without the ability to ensure that it is purchasing the best care for the best price, the county will grapple with decreasing services to decrease costs. Transparent information on cost and quality is key to having the best and most cost effective plans for employees. King county is recognized as a national leader on health care cost management. The savings have kept sheriffs in the field, prosecutors in court, and buses on the streets. The APCD needs cost data to generate savings. If nothing changes between now and 2018, the county will have an Affordable Care Act excise tax of \$21 million over 3 years. The county needs the data so it can plan, negotiate with unions, and avoid the tax costs. This will help PEBB and Medicaid too.

From a patient privacy perspective this is a small and positive investment. The bill addresses real problems, and it makes sense to only release semi-identified data with a certification that it will be used for the public interest.

A great deal of stakeholder work has gone into the bill.

There are some ideas to make the privacy provisions stronger, such as changing the definition of "personal identifier."

(Opposed) None.

Persons Testifying: Bob Crittenden, Office of the Governor; Patrick Connor, National Federation of Independent Business and Coalition for Health Care Cost Transparency; Laura Hitchcock, King County; and Chris Kaasa, American Civil Liberties Union of Washington.

Persons Signed In To Testify But Not Testifying: None.