SENATE BILL REPORT
SB 5084

As of February 10, 2015

Title: An act relating to clarifying the all payer claims database to improve health care quality and cost transparency by changing certain definitions regarding data, reporting and pricing of products, responsibility of the office and lead organization, and parameters for release of information.

Brief Description: Clarifying the all payer claims database to improve health care quality and cost transparency by changing certain definitions regarding data, reporting and pricing of products, responsibility of the office and lead organization, and parameters for release of information.

Sponsors: Senators Becker, Frockt, Conway, Keiser and Mullet; by request of Governor Inslee.

Brief History:
Committee Activity: Health Care: 2/10/15.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

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.

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.

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 of Bill: The bill as referred to committee not considered.

Summary of Bill (Proposed Substitute): Beginning no sooner than July 1, 2015, OFM must initiate a competitive process to select a lead organization for the initial contract term. The organization must be composed of health care purchasers, state-licensed insurers, union trusts, providers, and consumers. OFM must issue a request for information prior to issuing a competitive request for proposal. All documents must be posted on the OFM website.

The Medicaid program, the Public Employees Benefits Board program, and all health insurance carriers operating in this state must submit claims data. 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.

Proprietary financial information is defined to mean 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 an individual health care facility or provider, and a specific payer, or internal fee schedule or other internal pricing mechanism of integrated delivery systems owned by a carrier.

Responsibilities of the lead organization are modified to ensure the protection of proprietary financial information, allow the development of protocols for pre-release peer review by data suppliers, and the $5,000 cap on fees is removed. Any fees must be approved by OFM and should be comparable, accounting for relevant differences across data requests and uses. The advisory committees must 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: identity of any entities that will analyze the data; stated purpose of the request; description of the proposed methodology; specific variable requested; how the requester will ensure all data is handled to ensure privacy and confidentiality protection; 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 and OFM must create a process to govern three levels of access to the data:

1. Claims data that includes proprietary financial information or direct patient identifiers may be released only to:

a. federal, state, and local government agencies with a signed data use and confidentiality agreement, but they are prohibited from using such data in the purchase or procurement of health benefits for their employees;
b. a researcher or research organization with a signed data use and confidentiality agreement, but they must agree in writing not to disclose the data or parts of the data to any other party including affiliated entities; and
c. any entity when functioning as the organization;

2. Claims data that do not contain proprietary financial information or direct patient identifiers, but may contain indirect patient identifiers, may be released as approved by the lead organization; and
3. Claims data that do not contain direct or indirect patient identifiers and proprietary financial information may be released upon request.

Reports may not contain proprietary financial information, or direct or indirect patient identifiers. Reports issued by the lead organization may utilize propriety financial information to calculate aggregate cost data. OFM must develop in rule a format for the calculation and display of aggregate cost data. 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.

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 reports that 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 and therefore subject to the rules applied to all other entities seeking access to data.

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 has 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 has had on competition between and among providers, purchasers, and payers.

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: Last year's bill was limited but it gave us time to review issues more closely including areas that protect patient information. Eleven states have a mandatory all-payer claims database. Last year's bill established the framework of the all-payer claims database. Capturing information on price is critical, as is protecting the patient information. This bill provides enhanced protection while building transparency with health care cost data. The Alliance has had a voluntary database for quality information for ten years with no breaches of data. The state has earned an "A" grade for quality transparency reporting. The addition of pricing information can help the state move from an "F" grade on price transparency reports cards to an improved rating. The start-up and development work is funded with federal grants. The medical association introduced a database in 2011 and we are thrilled to support this version. Our concerns on privacy have been addressed in this version. The consumers are a big part of the equation. This can provide an effective tool to help consumers compare quality and cost information and make informed choices that will lower their costs. The all-payer claims database is an investment for all the people in the state.

Persons Testifying: PRO: Senator Becker, prime sponsor; Bob Crittenden, Governor's Office; Nancy Giunto, WA Health Alliance; Sydney Zvara, Assn. of WA Healthcare Plans; Katie Kolan, WA State Medical Assn.; Yanling Yu, WA Advocates for Patient Safety.