

# SENATE BILL REPORT

## ESSB 5084

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As Amended by House, April 14, 2015

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

**Brief History:**

**Committee Activity:** Health Care: 2/10/15, 2/19/15 [DPS, DNP, w/oRec].

Passed Senate: 3/10/15, 44-5.

Passed House: 4/14/15, 82-15.

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### SENATE COMMITTEE ON HEALTH CARE

**Majority Report:** That Substitute Senate Bill No. 5084 be substituted therefor, and the substitute bill do pass.

Signed by Senators Becker, Chair; Frockt, Ranking Minority Member; Angel, Bailey, Cleveland, Conway, Jayapal and Keiser.

**Minority Report:** Do not pass.

Signed by Senators Dammeier, Vice Chair; Brown.

**Minority Report:** That it be referred without recommendation.

Signed by Senator Parlette.

**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

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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 of Engrossed Substitute Bill:** OFM must initiate a competitive procurement process to select a lead organization and a data vendor. The proposal must include criteria to be applied in the scoring evaluation that include the following: extra points must be awarded based on the degree of experience in health care data collection, analysis, analytics, and security; extra points must be awarded for experience setting up an all-payer claims database in at least two other states; and extra points must be awarded for a long-term self-sustainable financial model. The successful lead organization must be certified as a qualified entity by the Centers for Medicare and Medicaid Services by December 31, 2017.

OFM must hold a separate contract with a data vendor that works at the direction of the lead organization to perform data collection, processing, aggregation, extracts, and analytics. Duties for the data vendor include the following: 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 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 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 applied 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; 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, and indirect patient may be released only to researchers with a signed data use and confidentiality agreement. Access for federal, state and local government agencies is removed, and access for the lead organization is removed;
- Claims data that do not contain proprietary financial information or direct patient identifiers may be released to agencies, researchers, and other entities with a signed data use agreement; and
- Claims data that do not contain proprietary financial information, direct patient identifiers, or indirect patient identifiers may be released upon request.

Reports may not contain proprietary financial information, or direct or indirect patient identifiers; however, aggregate zip codes, gender, and age may be used to generate reports so long as they cannot lead to the identification of an individual. Reports issued by the lead organization in conjunction with the data vendor 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. 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; nor attempt to determine the identify of any person whose information is included in the data set. The data must be destroyed or returned 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.

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.

**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 on Proposed Substitute as Heard in Committee:**  
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.

**House Amendment(s):** Definitions.

- Modifies the definition of "direct patient identifier" by adding account numbers, certificate or license numbers, vehicle identifiers and serial numbers, including license plate numbers, device identifiers and serial numbers, web universal resource locators, and Internet protocol address numbers. Removes from the definition birth month, birth day, contact information, and "any other data or records that can be directly connected to an individual."
- Modifies the definition of "indirect patient identifier" to mean a data variable that may identify an individual when combined with other information.
- Modifies the definition of "unique identifier" to mean an obfuscated identifier assigned to an individual represented in the database to establish a basis for following the individual longitudinally throughout different payers and encounters in the data without revealing the individual's identity.

Procurement

1. Requires OFM to award extra points to bidders with:
  - a. experience in convening and effectively engaging stakeholders to develop reports;
  - b. experience in meeting budget and timelines for report generations; and
  - c. an ability to combine cost and quality data. Removes the requirement to award extra points to a lead organization with experience reviewing and setting up a database in at least two other states.
2. Requires the lead organization to apply to be certified – rather than to be certified – as a qualified entity.
3. Requires the lead organization – rather than OFM – to enter into a contract with a data vendor.
4. Requires the lead organization to store and use any data – rather than just data with patient-specific or proprietary financial information – in a manner that protects privacy.

Submissions.

- Requires a data supplier used by an entity that voluntarily participates in the database to provide data to the data vendor – rather than to the lead organization.

Release of Claims Data.

1. Provides that data from the database may only be available for retrieval in processed form – rather than original or processed form.
2. Requires requests for data to include consent to penalties for inappropriate use or disclosure of indirect patient identifiers, in addition to direct patient identifiers and proprietary financial information.
3. Permits release of data that include unique identifiers to researchers. Requires researchers to consent to penalties for inappropriate use or disclosure of indirect patient identifiers, in addition to direct patient identifiers and proprietary financial information.
4. Permits release of data that do not contain direct patient identifiers, but that may contain proprietary financial information, indirect patient identifiers, unique identifiers, or a combination to:

- a. governmental agencies upon receipt of a data use agreement; and
  - b. any entity when functioning as the lead organization. Prohibits governmental agencies from using the data in the purchase or procurement of benefits for employees. Prohibits the lead organization from accessing data under this provision when acting in its capacity as a private entity.
5. Permits release of data that may contain unique identifiers – in addition to indirect patient identifiers – to agencies, researchers, and other entities approved by the lead organization.
  6. Provides that the act does not prohibit the use of geographic areas with a sufficient population size or aggregate gender, age, medical condition, or other characteristics – rather than aggregate zip codes, gender, and age – in generation of reports, so long as they cannot lead to the identification of an individual.
  7. Requires recipients of data to consent to penalties for inappropriate use or disclosure of indirect patient identifiers, in addition to direct patient identifiers and proprietary financial information.

#### Reports.

- Removes references to the lead organization issuing reports "in conjunction with the data vendor."
- Requires the lead organization to allow data suppliers, hospitals, and providers to verify the accuracy of information submitted to the data vendor – rather than to the lead organization.

#### Other.

- Requires OFM to adopt rules regarding penalties for inappropriate disclosure or use of indirect patient identifiers, in addition to direct patient identifiers and proprietary financial information.
- Makes several stylistic, grammatical, and technical changes – e.g., references the "chapter" rather than the "act" and requires the lead organization to design data mechanisms "ensuring," rather than "with an eye toward ensuring," the data submitted meet quality.