State of Washington   **69th Legislature**   **2025 Regular Session**

By Representatives Tharinger, Macri, Stonier, Thai, Parshley, Obras, Lekanoff, Davis, Simmons, Hill, and Ormsby; by request of Health Care Authority

Read first time 01/17/25.   Referred to Committee on Health Care & Wellness.

1   AN ACT Relating to modernizing the all payers claims database by
2   updating reporting requirements, data disclosure standards, and lead
3   organization requirements; and amending RCW 43.371.010, 43.371.020,
4   43.371.050, 43.371.060, 43.371.070, and 43.371.090.

5   BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6   **Sec. 1.** RCW 43.371.010 and 2019 c 319 s 2 are each amended to
7   read as follows:
8   The definitions in this section apply throughout this chapter
9   unless the context clearly requires otherwise.
10   (1) "Authority" means the health care authority.
11   (2) "Carrier" and "health carrier" have the same meaning as in
12   RCW 48.43.005.
13   (3) "Claims data" means the data required by RCW 43.371.030 to be
14   submitted to the database, including billed, allowed and paid
15   amounts, and such additional information as defined by the director
16   in rule.
17   (4) "Data supplier" means: (a) A carrier, third-party
18   administrator, or a public program identified in RCW 43.371.030 that
19   provides claims data; and (b) a carrier or any other entity that
20   provides claims data to the database at the request of an employer-

sponsored self-funded health plan or Taft-Hartley trust health plan pursuant to RCW 43.371.030(1).

(5) "Data vendor" means an entity contracted to perform data collection, processing, aggregation, extracts, analytics, and reporting.

(6) "Database" means the statewide all-payer health care claims database established in RCW 43.371.020.

(7) "Direct patient identifier" means a data variable that directly identifies an individual, including: Names; telephone numbers; fax numbers; social security number; medical record numbers; health plan beneficiary numbers; account numbers; certificate or license numbers; vehicle identifiers and serial numbers, including license plate numbers; device identifiers and serial numbers; web universal resource locators; internet protocol address numbers; biometric identifiers, including finger and voice prints; and full face photographic images and any comparable images.

(8) "Director" means the director of the authority.

(9) "Indirect patient identifier" means a data variable that may identify an individual when combined with other information.

(10) "Lead organization" means the organization selected under RCW 43.371.020.

(11) "Office" means the office of financial management.

(12) (("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 an individual health care facility or health care provider, as those terms are defined in RCW 48.43.005, and a specific payer, or internal fee schedule or other internal pricing mechanism of integrated delivery systems owned by a carrier.

(13))) "Unique identifier" means 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.

Sec. 2. RCW 43.371.020 and 2024 c 54 s 54 are each amended to read as follows:

(1) The office shall establish a statewide all-payer health care claims database. On January 1, 2020, the office must transfer

authority and oversight for the database to the authority. The office
and authority must develop a transition plan that sustains operations
by July 1, 2019. The database shall support transparent public
reporting of health care information. The database must improve
transparency to: Assist patients, providers, and hospitals to make
informed choices about care; enable providers, hospitals, and
communities to improve by benchmarking their performance against that
of others by focusing on best practices; enable purchasers to
identify value, build expectations into their purchasing strategy,
and reward improvements over time; and promote competition based on
quality and cost. The database must systematically collect all
medical claims and pharmacy claims from private and public payers,
with data from all settings of care that permit the systematic
analysis of health care delivery.

(2) The authority ((shall use)) may act as the lead organization,
or select a lead organization from among the best potential bidders
using a competitive procurement process, in accordance with chapter
39.26 RCW, ((to select a lead organization from among the best
potential bidders)) to coordinate and manage the database.

(a)(i) In conducting the competitive procurement, the authority
must ensure that no state officer or state employee participating in
the procurement process:

(A) Has a current relationship or had a relationship within the
last three years with any organization that bids on the procurement
that would constitute a conflict with the proper discharge of
official duties under chapter 42.52 RCW; or

(B) Is a compensated or uncompensated member of a bidding
organization's board of directors, advisory committee, or has held
such a position in the past three years.

(ii) If any relationship or interest described in (a)(i) of this
subsection is discovered during the procurement process, the officer
or employee with the prohibited relationship must withdraw from
involvement in the procurement process.

(b) Due to the complexities of the all-payer claims database and
the unique privacy, quality, and financial objectives, the authority
must give strong consideration to the following elements in
determining the appropriate lead organization contractor: (i) The
organization's degree of experience in health care data collection,
analysis, analytics, and security; (ii) whether the organization has
a long-term self-sustainable financial model; (iii) the

organization's experience in convening and effectively engaging
stakeholders to develop reports, especially among groups of health
providers, carriers, and self-insured purchasers; (iv) the
organization's experience in meeting budget and timelines for report
generations; and (v) the organization's ability to combine cost and
quality data to assess total cost of care.

(c) The successful lead organization must apply to be certified
as a qualified entity pursuant to 42 C.F.R. Sec. 401.703(a) by the
centers for medicare and medicaid services.

(d) The authority may not select a lead organization that:

(i) Is a health plan as defined by and consistent with the
definitions in RCW 48.43.005;

(ii) Is a hospital as defined in RCW 70.41.020;

(iii) Is a provider regulated under Title 18 RCW;

(iv) Is a third-party administrator as defined in RCW 70.290.010;
or

(v) Is an entity with a controlling interest in any entity
covered in (d)(i) through (iv) of this subsection.

(3) As part of the competitive procurement process referenced in
subsection (2) of this section, the lead organization shall enter
into a contract with a data vendor or multiple data vendors to
perform data collection, processing, aggregation, extracts, and
analytics. A data vendor must:

(a) Establish a secure data submission process with data
suppliers;

(b) Review data submitters' files according to standards
established by the authority;

(c) Assess each record's alignment with established format,
frequency, and consistency criteria;

(d) Maintain responsibility for quality assurance, including, but
not limited to: (i) The accuracy and validity of data suppliers'
data; (ii) accuracy of dates of service spans; (iii) maintaining
consistency of record layout and counts; and (iv) identifying
duplicate records;

(e) Assign unique identifiers, as defined in RCW 43.371.010, to
individuals represented in the database;

(f) Ensure that direct patient identifiers((,)) and indirect
patient identifiers((, and proprietary financial information)) are
released only in compliance with the terms of this chapter;

(g) Demonstrate internal controls and affiliations with separate organizations as appropriate to ensure safe data collection, security of the data with state of the art encryption methods, actuarial support, and data review for accuracy and quality assurance;

(h) Store data on secure servers that are compliant with the federal health insurance portability and accountability act and regulations, with access to the data strictly controlled and limited to staff with appropriate training, clearance, and background checks; and

(i) Maintain state of the art security standards for transferring data to approved data requestors.

(4) The lead organization and data vendor must submit detailed descriptions to Washington technology solutions to ensure robust security methods are in place. Washington technology solutions must report its findings to the authority and the appropriate committees of the legislature.

(5) The lead organization is responsible for internal governance, management, funding, and operations of the database. At the direction of the authority, the lead organization shall work with the data vendor to:

(a) Collect claims data from data suppliers as provided in RCW 43.371.030;

(b) Design data collection mechanisms with consideration for the time and cost incurred by data suppliers and others in submission and collection and the benefits that measurement would achieve, ensuring the data submitted meet quality standards and are reviewed for quality assurance;

(c) Ensure protection of collected data and store and use any data in a manner that protects patient privacy and complies with this section. All patient-specific information must be deidentified with an up-to-date industry standard encryption algorithm;

(d) Consistent with the requirements of this chapter, make information from the database available as a resource for public and private entities, including carriers, employers, providers, hospitals, and purchasers of health care;

(e) Report performance on cost and quality pursuant to RCW 43.371.060 using, but not limited to, the performance measures developed under RCW 41.05.690;

(f) Develop protocols and policies, including prerelease peer review by data suppliers, to ensure the quality of data releases and reports;

(g) Develop a plan for the financial sustainability of the database as may be reasonable and customary as compared to other states' databases and charge fees for reports and data files as needed to fund the database. Any fees must be approved by the authority and should be comparable, accounting for relevant differences across data requests and uses. The lead organization may not charge providers or data suppliers fees other than fees directly related to requested reports and data files; and

(h) Convene advisory committees with the approval and participation of the authority, including: (i) A committee on data policy development; and (ii) a committee to establish a data release process consistent with the requirements of this chapter and to provide advice regarding formal data release requests. The advisory committees must include in-state representation from key provider, hospital, public health, health maintenance organization, large and small private purchasers, consumer organizations, and the two largest carriers supplying claims data to the database.

(6) The lead organization governance structure and advisory committees for this database must include representation of the third-party administrator of the uniform medical plan. A payer, health maintenance organization, or third-party administrator must be a data supplier to the all-payer health care claims database to be represented on the lead organization governance structure or advisory committees.

Sec. 3. RCW 43.371.050 and 2019 c 319 s 5 are each amended to read as follows:

(1) Except as otherwise required by law, claims or other data from the database shall only be available for retrieval in processed form to public and private requesters pursuant to this section and shall be made available within a reasonable time after the request. Each request for claims data must include, at a minimum, the following information:

(a) The identity of any entities that will analyze the data in connection with the request;

(b) The stated purpose of the request and an explanation of how
the request supports the goals of this chapter set forth in RCW
43.371.020(1);

(c) A description of the proposed methodology;

(d) The specific variables requested and an explanation of how
the data is necessary to achieve the stated purpose described
pursuant to (b) of this subsection;

(e) How the requester will ensure all requested data is handled
in accordance with the privacy and confidentiality protections
required under this chapter and any other applicable law;

(f) The method by which the data will be destroyed at the
conclusion of the data use agreement;

(g) The protections that will be utilized to keep the data from
being used for any purposes not authorized by the requester's
approved application; and

(h) Consent to the penalties associated with the inappropriate
disclosures or uses of direct patient identifiers((,)) or indirect
patient identifiers((, or proprietary financial information)) adopted
under RCW 43.371.070(1).

(2) The lead organization may decline a request that does not
include the information set forth in subsection (1) of this section
that does not meet the criteria established by the lead
organization's data release advisory committee, or for reasons
established by rule.

(3) Except as otherwise required by law, the authority shall
direct the lead organization and the data vendor to maintain the
confidentiality of claims or other data it collects for the database
that include ((proprietary financial information,)) direct patient
identifiers, indirect patient identifiers, or any combination
thereof. Any entity that receives claims or other data must also
maintain confidentiality, including by agreeing to not reidentify any
deidentified patient information, and may only release such claims
data or any part of the claims data if:

(a) The claims data does not contain ((proprietary financial
information,)) direct patient identifiers, indirect patient
identifiers, or any combination thereof; and

(b) The release is described and approved as part of the request
in subsection (1) of this section.

(4) The lead organization shall, in conjunction with the
authority and the data vendor, create and implement a process to

1 govern levels of access to and use of data from the database
2 consistent with the following:

3 (a) Claims or other data that include ((~~proprietary financial~~
4 ~~information,~~)) direct patient identifiers, indirect patient
5 identifiers, unique identifiers, or any combination thereof may be
6 released only to the extent such information is necessary to achieve
7 the goals of this chapter set forth in RCW 43.371.020(1) to
8 researchers with approval of an institutional review board upon
9 receipt of a signed data use and confidentiality agreement with the
10 lead organization. A researcher or research organization that obtains
11 claims data pursuant to this subsection must agree in writing not to
12 disclose such data or parts of the data set to any other party,
13 including affiliated entities, and must consent to the penalties
14 associated with the inappropriate disclosures or uses of direct
15 patient identifiers((~~,~~)) or indirect patient identifiers((~~, or~~
16 ~~proprietary financial information~~)) adopted under RCW 43.371.070(1).

17 (b) Claims or other data that do not contain direct patient
18 identifiers, but that may contain ((~~proprietary financial~~
19 ~~information,~~)) indirect patient identifiers, unique identifiers, or
20 any combination thereof may be released to:

21 (i) Federal, state, tribal, and local government agencies upon
22 receipt of a signed data use agreement with the authority and the
23 lead organization((~~. Federal, state, tribal, and local government~~
24 ~~agencies that obtain claims data pursuant to this subsection are~~
25 ~~prohibited from using such data in the purchase or procurement of~~
26 ~~health benefits for their employees~~));

27 (ii) Any entity when functioning as the lead organization under
28 the terms of this chapter; ((~~and~~))

29 (iii) The Washington health benefit exchange established under
30 chapter 43.71 RCW, upon receipt of a signed data use agreement with
31 the authority and the lead organization as directed by rules adopted
32 under this chapter; and

33 (iv) Agencies, researchers, and other entities as approved by the
34 lead organization upon receipt of a signed data use agreement with
35 the authority and the lead organization.

36 (c) ((~~Claims or other data that do not contain proprietary~~
37 ~~financial information, direct patient identifiers, or any combination~~
38 ~~thereof, but that may contain indirect patient identifiers, unique~~
39 ~~identifiers, or a combination thereof may be released to agencies,~~
40 ~~researchers, and other entities as approved by the lead organization~~

1 ~~upon receipt of a signed data use agreement with the lead~~
2 ~~organization.~~

3   ((~~(d)~~)) Claims or other data that do not contain direct patient
4 identifiers, indirect patient identifiers, ((~~proprietary financial~~
5 ~~information,~~)) or any combination thereof may be released upon
6 request.

7   (5) Reports utilizing data obtained under this section may not
8 contain ((~~proprietary financial information,~~)) direct patient
9 identifiers, indirect patient identifiers, or any combination
10 thereof. Nothing in this subsection (5) may be construed to prohibit
11 the use of geographic areas with a sufficient population size or
12 aggregate gender, age, medical condition, or other characteristics in
13 the generation of reports, so long as they cannot lead to the
14 identification of an individual.

15   (6) ((~~Reports issued by the lead organization at the request of~~
16 ~~providers, facilities, employers, health plans, and other entities as~~
17 ~~approved by the lead organization may utilize proprietary financial~~
18 ~~information to calculate aggregate cost data for display in such~~
19 ~~reports. The authority shall approve by rule a format for the~~
20 ~~calculation and display of aggregate cost data consistent with this~~
21 ~~chapter that will prevent the disclosure or determination of~~
22 ~~proprietary financial information. In developing the rule, the~~
23 ~~authority shall solicit feedback from the stakeholders, including~~
24 ~~those listed in RCW 43.371.020(5)(h), and must consider, at a~~
25 ~~minimum, data presented as proportions, ranges, averages, and~~
26 ~~medians, as well as the differences in types of data gathered and~~
27 ~~submitted by data suppliers.~~

28   ((~~(7)~~)) Recipients of claims or other data under subsection (4) of
29 this section must agree in a data use agreement or a confidentiality
30 agreement to, at a minimum:

31   (a) Take steps to protect data containing direct patient
32 identifiers, indirect patient identifiers, ((~~proprietary financial~~
33 ~~information,~~)) or any combination thereof as described in the
34 agreement;

35   (b) Not redisclose the claims data except pursuant to subsection
36 (3) of this section;

37   (c) Not attempt to determine the identity of any person whose
38 information is included in the data set or use the claims or other
39 data in any manner that identifies any individual or their family or
40 attempt to locate information associated with a specific individual;

(d) Destroy claims data at the conclusion of the data use agreement; and

(e) Consent to the penalties associated with the inappropriate disclosures or uses of direct patient identifiers((,)) or indirect patient identifiers((, or proprietary financial information)) adopted under RCW 43.371.070(1).

Sec. 4. RCW 43.371.060 and 2020 c 131 s 1 are each amended to read as follows:

(1)(a) Under the supervision of and through contract with the authority, the lead organization shall prepare health care data reports using the database and the statewide health performance and quality measure set. Prior to the lead organization releasing any health care data reports that use claims data, the lead organization must submit the reports to the authority for review.

(b) By October 31st of each year, the lead organization shall submit to the director a list of reports it anticipates producing during the following calendar year. The director may establish a public comment period not to exceed thirty days, and shall submit the list and any comment to the appropriate committees of the legislature for review.

(2)(a) Health care data 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 by reporting on:

(i) Whether providers and health systems deliver efficient, high quality care; and

(ii) Geographic and other variations in medical care and costs as demonstrated by data available to the lead organization.

(b) Measures in the health care data reports should be stratified by demography, income, language, health status, and geography when feasible with available data to identify disparities in care and successful efforts to reduce disparities.

(c) Comparisons of costs among providers and health care systems must account for differences in the case mix and severity of illness of patients and populations, as appropriate and feasible, and must take into consideration the cost impact of subsidization for uninsured and government-sponsored patients, as well as teaching expenses, when feasible with available data.

1   (3) The lead organization may not publish any data or health care
2 data reports that:
3   (a) Directly or indirectly identify individual patients;
4   (b) ((~~Disclose a carrier's proprietary financial information;~~
5   ~~(c)~~)) Compare performance in a report generated for the general
6 public that includes any provider in a practice with fewer than four
7 providers; or
8   (((~~d~~))) (c) Contain medicaid data that is in direct conflict with
9 the biannual medicaid forecast.
10   (4) The lead organization may not release a report that compares
11 and identifies providers, hospitals, or data suppliers unless:
12   (a) It allows the data supplier, the hospital, or the provider to
13 verify the accuracy of the information submitted to the data vendor,
14 comment on the reasonableness of conclusions reached, and submit to
15 the lead organization and data vendor any corrections of errors with
16 supporting evidence and comments within thirty days of receipt of the
17 report;
18   (b) It corrects data found to be in error within a reasonable
19 amount of time; and
20   (c) The report otherwise complies with this chapter.
21   (5) The authority and the lead organization may use claims data
22 to identify and make available information on payers, providers, and
23 facilities, but may not use claims data to recommend or incentivize
24 direct contracting between providers and employers.
25   (6) The lead organization shall make information about claims
26 data related to the provision of air ambulance service available on a
27 website that is accessible to the public in a searchable format by
28 geographic region, provider, and other relevant information.
29   (7)(a) The lead organization shall distinguish in advance to the
30 authority when it is operating in its capacity as the lead
31 organization and when it is operating in its capacity as a private
32 entity. Where the lead organization acts in its capacity as a private
33 entity, it may only access data pursuant to RCW 43.371.050(4) (b)
34 ((~~,~~)) (iv) or (c)((~~, or (d)~~)).
35   (b) Except as provided in RCW 43.371.050(4), claims or other data
36 that contain direct patient identifiers ((~~or proprietary financial~~
37 ~~information~~)) must remain exclusively in the custody of the data
38 vendor and may not be accessed by the lead organization.

Sec. 5. RCW 43.371.070 and 2019 c 319 s 7 are each amended to read as follows:

(1) The director shall adopt any rules necessary to implement this chapter, including:

(a) Definitions of claim and data files that data suppliers must submit to the database, including: Files for covered medical services, pharmacy claims, and dental claims; member eligibility and enrollment data; and provider data with necessary identifiers;

(b) Deadlines for submission of claim files;

(c) Penalties for failure to submit claim files as required;

(d) Procedures for ensuring that all data received from data suppliers are securely collected and stored in compliance with state and federal law;

(e) Procedures for ensuring compliance with state and federal privacy laws;

(f) Procedures for establishing appropriate fees;

(g) Procedures for data release;

(h) Penalties associated with the inappropriate disclosures or uses of direct patient identifiers((,)) and indirect patient identifiers((, and proprietary financial information)); and

(i) A minimum reporting threshold below which a data supplier is not required to submit data.

(2) The director may not adopt rules, policies, or procedures beyond the authority granted in this chapter.

Sec. 6. RCW 43.371.090 and 2024 c 54 s 50 are each amended to read as follows:

(1) To ensure the database is meeting the needs of state agencies and other data users, the authority shall convene a state agency coordinating structure, consisting of state agencies with related data needs and the Washington health benefit exchange to ensure effectiveness of the database and the agencies' programs. The coordinating structure must collaborate in a private/public manner with the lead organization and other partners key to the broader success of the database. The coordinating structure shall advise the authority and lead organization on the development of any database policies and rules relevant to agency data needs.

(2) The office must participate as a key part of the coordinating structure and evaluate progress towards meeting the goals of the database, and, as necessary, recommend strategies for maintaining and

1 promoting the progress of the database in meeting the intent of this
2 section, and report its findings ((biennially)) every five years to
3 the governor and the legislature. The authority shall facilitate the
4 office obtaining the information needed to complete the report in a
5 manner that is efficient and not overly burdensome for the parties.
6 The authority must provide the office with access to database
7 processes, procedures, nonproprietary methodologies, and outcomes to
8 conduct the review and issue the ((biennial)) five-year report. The
9 ((biennial)) five-year review shall assess, at a minimum the
10 following:
11   (a) The list of approved agency use case projects and related
12 data requirements under RCW 43.371.050(4);
13   (b) Successful and unsuccessful data requests and outcomes
14 related to agency and nonagency health researchers pursuant to RCW
15 43.371.050(4);
16   (c) Online data portal access and effectiveness related to
17 research requests and data provider review and reconsideration;
18   (d) Adequacy of data security and policy consistent with the
19 policy of Washington technology solutions; and
20   (e) Timeliness, adequacy, and responsiveness of the database with
21 regard to requests made under RCW 43.371.050(4) and for potential
22 improvements in data sharing, data processing, and communication.
23   (3) To promote the goal of improving health outcomes through
24 better cost and quality information, the authority, in consultation
25 with the agency coordinating structure, the office, lead
26 organization, and data vendor shall make recommendations to the
27 Washington state performance measurement coordinating committee as
28 necessary to improve the effectiveness of the state common measure
29 set as adopted under RCW 70.320.030.

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