DATA COLLECTION/RELEASE SURVEY
CMS & All-Payer Claims Databases

Federal – CMS

	Definitions	Access to Data
CMS Medicare Data	**Personally Identifiable Information**: Information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual. OMB-M-10-23. **Protected Health Information**: Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. 45 C.F.R. § 160.103. It excludes, however, individually identifiable health information: • In education records covered by the Family Educational Rights and Privacy Act. • In records on a student who is 18+ that are used only in connection with the provision of treatment to the student and are not available to anyone other than the person providing such treatment. • In employment records held by a covered entity in its role as employer. • Regarding a person who has been deceased for more than 50 years. 45 C.F.R. § 160.103	CMS releases data files to certain parties as allowed by federal regulations and its own policy. CMS enters into Data Use Agreements (DUA) with data requesters for disclosures of protected health information (PHI) and/or personally identifiable information (PII). CMS maintains three different categories of data files: • *Identifiable Data Files (IDFs).* IDFs contain PHI and/or PII and are only available to certain stakeholders through custom requests that require a DUA. CMS allows organizations to access IDFs for research purposes. Requests for these data files require a research protocol and DUA, among other documents, and are reviewed by CMS' Privacy Board. *See* Identifiable Data Files for more information on the research request process. • *Limited Data Set Files (LDS).* LDS contain PHI, but they do not contain specific direct identifiers. LDS files are available for research use, and requestors must complete a DUA. *See* Data Disclosures and Data Use Agreements and Limited Data Set Files for general guidelines for submission of DUAs and more information on LDS. • *Public Use Files (PUFs).* PUFs (i.e., non-identifiable data files) contain aggregate level data on Medicare beneficiary or provider utilization. Requests for public use files do not require a DUA and can be received via application. *See* Non-Identifiable Data Files for how to purchase such a data set. CMS has released a series of PUFs that summarize the utilization and payments for procedures, services, and prescription drugs provided to Medicare beneficiaries by specific inpatient and outpatient hospitals, physicians, and other suppliers. Specifically, CMS has published the following: • *Physician and Other Supplier PUF*. Information on services and procedures provided to Medicare beneficiaries by physicians and other health care professionals (e.g., data on utilization, payment, submitted charges, and place of service). • *Inpatient PUF*. Information on inpatient discharges for Medicare fee-for-service beneficiaries (e.g., data on utilization, payment, and hospital-specific charges). • *Outpatient PUF*. Information on common outpatient services provided to Medicare fee-for-service beneficiaries (e.g., data on utilization, payment, and estimated hospital-specific charges). • *Part D Prescriber PUF*. Information on prescription drugs prescribed by individual physicians and other health care providers and paid for under Part D (e.g., the total number of prescriptions that were dispensed and the total drug cost).

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		• *Referring Durable Medical Equipment, Prosthetics, Orthotics, and Supplies PUF*. Information on such products and services provided to Medicare beneficiaries ordered by physicians and other health care professionals (e.g., data on utilization, payment, and submitted charges). • *Home Health Agency PUF*. Information on services provided to Medicare beneficiaries by home health agencies (e.g., data on utilization, payment, submitted charges, demographic and chronic condition indicators, and state of service). • *Skilled Nursing Facility PUF*. Information on services provided to Medicare beneficiaries residing in skilled nursing facilities (e.g., data on utilization, payment, submitted charges, beneficiary demographic and chronic condition indicators, and state of service). • *Hospice Utilization and Payment PUF*. Information on services provided to Medicare beneficiaries by hospice providers (e.g., data on utilization payment, submitted charges, primary diagnoses, sites of service, hospice beneficiary demographics, and state). Additionally, CMS has put forth a Medicare Claims Synthetic PUF to allow interested parties to gain familiarity using Medicare claims data while protecting beneficiary privacy. The files represent a synthetic 5% sample of beneficiaries and their claims from 2008-2010. FAQs. This PUF allows data entrepreneurs to develop and create software and applications that may eventually be applied to actual CMS claims data (i.e., LDS). Other available data sets can be found here and comparisons of claims data/quality of care can be found here.
CMS Medicare Advantage Data	**Encounter Data**: Detailed data generated by health care providers, such as doctors and hospitals, that documents both the clinical conditions they diagnose as well as the services and items delivered to beneficiaries to treat these conditions. AHIP's Medicare Advantage Encounter Data: What You Need to Know.	CMS has expanded the data available to researchers starting with 2015 Medicare Advantage (MA) encounter data, which provides detailed information about services to beneficiaries enrolled in an MA managed care plan in calendar year 2015. *See* CMS Press Release (Apr. 26, 2018).

State – APCD

State	Definitions	Submission of Data	Release of Data
Arkansas ARK. CODE ANN. § 32-61-901 et seq.; Rule 100	**Submitting Entity**: A submitting entity includes: • An entity that provides health or dental insurance or a health or dental benefit plan in Arkansas (e.g., an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, or fraternal benefit society), provided the entity has at least 2,000 Arkansas enrollees ("covered individuals"). • A health benefit plan offered/administered by/on behalf of the state or instrumentality thereof. • A health benefit plan offered/administered by/on behalf of the federal government with the agreement of the federal government. • The Workers' Compensation Commission. • Any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, a third-party administrator, or a pharmacy benefits manager, provided the entity has at least 2,000 Arkansas enrollees ("covered individuals"). • An ERISA health benefit plan, provided that the health benefit plan does not include an employee welfare benefit plan that is also a trust established pursuant to collective bargaining subject to the Labor Management Relations Act of 1947. • An entity that contracts with institutions of the Department of Correction or Department of Community Correction to provide medical, dental, or pharmaceutical care to inmates. A submitting entity does not include an entity that provides health insurance or a health benefit plan that is accident-only, specified disease, hospital indemnity, long-term care, disability income, Medicare supplement, or other supplemental benefit coverage where benefits are paid directly to the covered	Generally, a submitting entity must submit data sets for an enrollment file, a medical claims file, a dental claims file, and pharmacy claims file, a provider file, and a validation report and submit it to the Arkansas Insurance Department on a quarterly basis. Rule 100 § 4(11), 5. Such data sets must contain the following information: • Health and dental claims data (i.e., information included in an institutional, professional, or pharmacy claim or equivalent information transaction for a covered individual, including the amount paid to a provider of healthcare services plus any amount owed by the covered individual). • Unique identifiers (i.e., non-direct personal identifiers), and geographic and demographic information for covered individuals. • Provider files. ARK. CODE ANN. § 32-61-906(a); ARK. CODE ANN. § 23-61-903(3). For additional information on the submission of data, *see* the Arkansas Data Submission Guide. Exemptions • An entity with fewer than 2,000 covered individuals as of December 31 of the previous calendar year will not be required to submit data in accordance with Arkansas law. • The Arkansas Workers' Compensation Commission is exempt from submitting a provider file. • Employer self-funded health plans are exempt from all submission requirements. Submitting entities may also request an exemption for all or some parts of the rule. Rule 100 § 5(C).	The data in the Arkansas Healthcare Transparency Initiative must be available: • As a resource to insurers, employers, purchasers of healthcare, researchers, state agencies, and healthcare providers to allow for assessment of healthcare utilization, expenditures, and performance, provided that the data is disclosed in a form and manner that ensures the privacy and security of protected health information as required by state and federal law. • To state programs regarding healthcare quality and costs for use in improving healthcare in the state, subject to rules prescribed by the Arkansas Insurance Department conforming to state and federal privacy laws or limiting access to limited-use data sets. ARK. CODE ANN. § 32-61-907(a). The data may not be used to: • Disclose trade secrets of submitting entities; • Re-identify or attempt to re-identify an individual who is the subject of any submitted data without obtaining the individual's consent; or • Create or augment data contained in a national claims database. Additionally, notwithstanding HIPAA or other provisions of law, the Arkansas Healthcare Transparency Initiative cannot publicly disclose any data that contains direct personal identifiers. ARK. CODE ANN. § 32-61-907(b).

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	individual. ARK. CODE ANN. § 23-61-903(9); Rule 100 § 4(21), 6(B). **Covered Individual**: A natural person who is an Arkansas resident and is eligible to receive medical, dental, or pharmaceutical coverage. ARK. CODE ANN. § 23-61-903(4).		
Colorado COLO. REV. STAT. ANN. § 25.5-1-204; 10 CCR 1.200 et seq.	**Payer**: A private health care payer and a public health care payer. 10 CCR 1.200.1. **Private Health Care Payer**: An insurance carrier covering 1,000 or more enrolled lives in health coverage plans in Colorado. The term includes: • Carriers offering health benefits plans and dental, vision, limited benefit health insurance, and short-term limited-duration health insurance. • A self-insured employer-sponsored health plan covering an aggregate of 100 or more enrolled lives in Colorado. The term does <u>not</u> include a self-insured employer-sponsored health plan, if such health plan is administered by a third-party administrator or administrative services only organization that services: • Less than an aggregate of 1,000 enrolled lives in Colorado. Carriers offering accident only. Credit. Benefits for long term care, home health care, community-based care, or any combination thereof under Colorado law. Disability income insurance. Liability insurance including general liability insurance and automobile liability insurance. Coverage issued as a supplement to liability insurance. Worker's compensation or similar insurance.	Payers are required to submit complete and accurate data files to the APCD on a monthly basis, including eligibility data files, medical claims data files, pharmacy claims data files, dental claims data files, and provider files. 10 CCR 1.200.2.A, 1.200.3.C. • *Eligibility Data File*. A file that includes data about a person who receives health care coverage from a payer. 10 CCR 1.200.1. • *Medical Claims Data File*. A file that includes data about medical claims and other encounter information. 10 CCR 1.200.1. • *Pharmacy File*. A file that includes data about prescription medications and claims filed by pharmacies. 10 CCR 1.200.1. • *Dental Claims File*. A file that includes data about dental claims and other encounter information. 10 CCR 1.200.1. • *Provider Files*. A file that includes additional information about the individuals and entities that submitted claims that are included in the medical claims file. 10 CCR 1.200.1. <u>Exemption</u> A private health care payer subject to the provisions of ERISA is not required to submit claims data but may continue to submit claims data or elect to submit claims data at any time. 10 CCR 1.200.2.B.	The APCD must, at a minimum, issue reports from the APCD data at an aggregate level to describe patterns of incidence and variation of targeted medical conditions, state and regional cost patterns, and utilization of services. 10 CCR 1.200.4.A. The APCD reports must be available to the public on a consumer-facing website. 10 CCR 1.200.4.B. Specifically, the data in the APCD should be made available to: • The public as a resource to insurers, consumers, employers, providers, purchasers of health care, and state agencies to allow for continuous review of health care utilization, expenditures, and quality and safety performance in the state, provided that the data is disclosed in a form and manner that ensures privacy and security of personal health information, as required by state and federal law. • State agencies and private entities in Colorado engaged in efforts to improve health care. • Facilitate comparisons of geographic, demographic, and economic factors and institutional size. COLO. REV. STAT. ANN. § 25.5-1-204(7). Any such reports, however, must protect patient identity in accordance with HIPAA's standard for the de-identification of protected health information. 10 CCR 1.200.4.B.

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	Automobile medical payment insurance, specified disease, or hospital indemnity and other fixed indemnity insurance. 10 CCR 1.200.1. **Public Health Care Payer**: The Colorado Medicaid program, the children's basic health plan, and Cover Colorado. 10 CCR 1.200.1.		Finally, a state agency or private entity engaged in efforts to improve health care quality, value, or public health outcomes for Colorado residents may request a specialized report or data set from the APCD by submitting a written request detailing the purpose of the project, the methodology, the qualifications of the research entity, and by executing a data use agreement, to comply with the requirements of HIPAA. 10 CCR 1.200.5.A.
Connecticut CONN. GEN. STAT. ANN. § 19a-755a	**Reporting Entity**: A reporting entity is: • An insurer licensed to do health insurance business in Connecticut. • A heath care center. • An insurer or health care center that provides coverage under Medicare to Connecticut residents. • A third-party administrator. • A pharmacy benefits manager. • A hospital service corporation. • A nonprofit medical service corporation. • A fraternal benefit society that transacts health insurance business in Connecticut. • A dental plan organization. • Any other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments. CONN. GEN. STAT. ANN. § 19a-755a(a)(2).	Generally, a reporting entity is required to report health care information—relating to medical insurance claims, dental insurance claims, pharmacy claims, and other insurance claims information from enrollment and eligibility files—for inclusion in the APCD. Additionally, the Commissioner of Social Services must submit Medicaid and CHIP data to the executive director of the Office of Health Strategy for inclusion in the APCD only for purposes related to administration of the state Medicaid and CHIP plans. CONN. GEN. STAT. ANN. § 19a-755a(b)(4). For additional information on the submission of data, *see* the Connecticut Data Submission Guide. <u>Exemptions</u> An ERISA employee welfare benefit plan that is also a trust established pursuant to collective bargaining subject to the Labor Management Relations Act is not required to submit the required data. CONN. GEN. STAT. ANN. § 19a-755a(a)(2).	The executive director of the Office of Health Strategy is required to make data in the APCD available to any state agency, insurer, employer, health care provider, consumer of health care services, or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. If health information is permitted to be disclosed under HIPAA, or regulations adopted thereunder, any disclosure thereof made pursuant to Connecticut law must have identifiers removed. CONN. GEN. STAT. ANN. § 19a-755a(b)(5).
Delaware DEL. CODE ANN. tit. 16, § 10311	**Mandatory Reporting Entity**: Any of the following, except as prohibited under federal law: • The State Employee Benefits Committee and the Office of Management and Budget. • Any health insurer, third party administrator, or other entity that receives or collects	A mandatory reporting entity must submit required claims data to the Delaware Health Care Claims Database by the reporting date. Required claims data includes the following: • Basic demographic information, including the patient's gender, age, and geographic area of residency;	The Delaware Health Insurance Network must provide access to: • Health care payers, providers, and purchasers with access to the Delaware Health Care Claims Database to facilitate the design and evaluation of alternative delivery and payment models, including

State	Definitions	Submission of Data	Release of Data
	premiums/adjusts or settles health claims for any state employee (or their spouses or dependents), participating in the State Group Health Insurance Program. • The Division of Medicaid and Medical Assistance, with respect to services provided under the Medicaid and State Children's Health Insurance Program. • Any health insurer or other entity that is certified as a qualified health plan on the state insurance marketplace for the current year or any subsequent plan year. • Any federal health insurance plan providing health care services to a Delaware resident, including Medicare and the Federal Employees Health Benefits Plan. DEL. CODE ANN. tit. 16, § 10312(8). **Voluntary Reporting Entity**: Any of the following entities, unless such entity is a mandatory reporting entity: • Any health insurer. • Any third party administrator. • Any entity, which is not a health insurer or third party administrator, when such entity receives or collects premiums/adjusts or settles health claims for any Delaware resident. DEL. CODE ANN. tit. 16, § 10312(10).	• Basic information relating to an individual episode of care, including the date and time of the patient's admission and discharge; the identity of the health-care services provider; and the location and type of facility, such as a hospital, office, or clinic, where the service was provided. • Information describing the nature of health-care services provided to the patient in connection with the encounter, visit, or service, including diagnosis codes. • Health insurance product type, such as HMO or PPO. • Pricing information. DEL. CODE ANN. tit. 16, §§ 10312(1), (6), 10313(a)(1). In instances where more than one entity is involved in the administration of a policy, a health insurer is responsible for submitting the claims data on policies that it has written; the third party administrator, on the other hand, is responsible for submitting claims data on self-insured plans that it administers. DEL. CODE ANN. tit. 16, § 10315(c). Additionally, the Delaware Health Information Network has the authority to collect claims data from voluntary reporting entities as per a data submission and use agreement. DEL. CODE ANN. tit. 16, § 10315(b). <u>Exemptions</u> The required claims data reporting requirements do not apply to required claims data created for any employee welfare benefit plan or other employee health plan that is regulated by ERISA, unless otherwise permitted by federal law or regulation. DEL. CODE ANN. tit. 16, § 10313(a)(5). The Delaware Health Information Network has the authority to promulgate a template for a data submission and use agreement for the submission of required claims data by a mandatory reporting entity. DEL. CODE ANN. tit. 16, § 10313(a)(3)-(4).	population health research and provider risk-sharing arrangements. DEL. CODE ANN. tit. 16, § 10314(a). • The Office of Management and Budget, State Employee Benefits Committee, Division of Public Health, and Division of Medicaid and Medical Assistance to facilitate public health improvement research and activities. DEL. CODE ANN. tit. 16, § 10314(c). Additionally, the Delaware Health Insurance Network is permitted to promulgate regulations to make certain non-individually identifiable data extracts and analyses available to the public. DEL. CODE ANN. tit. 16, § 10314(d). Such data must be provided under confidentiality and data security protocols and in compliance with all applicable state and federal laws. DEL. CODE ANN. tit. 16, § 10314(f). Beyond identifying which entities have access to the data, the Delaware Health Insurance Network is also required to promulgate regulations governing notification requirements when claims data is released. DEL. CODE ANN. tit. 16, § 10314(e).
Florida			

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FLA. ADMIN. CODE § 59E-9.010.	**Payer**: Health insurers, or health maintenance organizations that participate in the Florida state group insurance plan or Medicaid managed care. FLA. ADMIN. CODE § 59E-9.010(1)(g). **Covered Lives**: Individuals for whom Florida claims data is held by the payer inclusive of insureds, individual policyholders, group certificate-holders, subscribers, members and dependents. FLA. ADMIN. CODE § 59E-9.010(1)(d).	Payers shall submit claims data for all covered lives to the Florida Agency for Health Care Administration. Claims data includes complete and accurate member eligibility data, medical claims data, and pharmacy claims data. • *Member Eligibility Data*. Information on every member enrolled with the health plan during the specified data period. Florida Data Submission Guide, at 8. • *Medical Claims Data*. Claims data for inpatient, outpatient, and professional services. Florida Data Submission Guide, at 10. • Pharmacy Claims Data. Claims submitted by pharmacies for member prescriptions filled in retail, mail, and specialty pharmacy settings. FLA. ADMIN. CODE § 59E-9.010(1)(c); Florida Data Submission Guide, at 19. For additional information on the submission of data, *see* the Florida Data Submission Guide. Exemptions • Payers are exempt from providing claims data from health plans covered by ERISA when such employers would prefer not to share such claims data. FLA. ADMIN. CODE § 59E-9.010(2)(b). • Certain coverages are exempt from the data collection requirement. FLA. ADMIN. CODE § 59E-9.010(2)(c).	The Florida Agency for Health Care Administration is required to publish and make available to the public on a consumer-friendly website estimated pricing data (de-identified in accordance with HIPAA) based on the claims data. FLA. ADMIN. CODE § 59E-9.010(5)(a). For more on the consumer-friendly platform, *see* FLA. STAT. ANN. § 408.05(3)(c).
Hawaii HAW. REV. STAT. § 323D-18.5.	**Provider of Health Insurance**: A group health insurance contract or service agreement that may include medical services, hospital services, surgical services, prescription drug services, vision services, or dental services in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of the services, including third party administrators. HAW. REV. STAT. § 323D-18.5(l).	Providers of health insurance that provide health benefit plans funded by the Hawaii employer-union health benefits trust fund, the state Medicaid agency, or both must provide the state agency with administrative data required by the State Health Planning and Development Agency to determine health benefits costs, including health care services claims and payment data regarding beneficiaries of health benefit plans funded by the Hawaii employer-union health benefits trust fund, the state Medicaid agency, or both. HAW. REV. STAT. § 323D-18.5(b). Providers of health insurance doing business in Hawaii may submit to the State Health Planning and Development Agency with administrative	The state agency is required to submit data collected to the college of social sciences, social sciences research institute, pacific health informatics and data center at the University of Hawaii for processing, assignment of encrypted identifiers, and any other task deemed necessary by the state agency. The state agency is also permitted to: • Contract with entities for the analysis of data collected and processed by a data center to benefit Medicaid and Medicare recipients, public

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		data that the Agency deems necessary to perform its functions. HAW. REV. STAT. § 323D-18.5(a). The administrative data reported by both providers includes: • Statistical and financial reports of information. • Patient invoices or similar patient encounter data. • Records of services used for or resulting from administering delivery of health care, pharmacy benefits, or dental care (including records of services provided under health benefits plans as defined under state law). • Any other records as established pursuant to administrative rules. HAW. REV. STAT. § 323D-18.5(l).	employees, and public sector retirees, and for other public purposes. HAW. REV. STAT. § 323D-18.5(c). • Acquire federal Medicare data set specific to Hawaii and made available to states. HAW. REV. STAT. § 323D-18.5(j). The state agency is required to develop and update an annual plan for the analysis, maintenance, and publication of data collected. HAW. REV. STAT. § 323D-18.5(d). Finally, to minimize any risk of data breaches and reidentification of data, the data and information submitted to the state agency shall include only the minimum protected health information identifiers necessary to link public and private data sources and the geographic and services data to undertake studies. § 323D-18.5(g). The state agency (and any recipient of the data collected) is required to maintain the original protected health information identifier in a separate database that is not linked with any other data and must use a proxy or encrypted record identifier for data analysis. HAW. REV. STAT. § 323D-18.5(h).
Maine ME. REV. STAT. tit. 22, § 8701 et seq.; 90-590-120 ME. CODE R. § 1 et seq.; 90-590-243 ME. CODE R. § 1 et seq. ***The APCD contains claims data submitted by*	**Health Care Claims Processor**: A third-party payer, third-party administrator, Medicare health plan sponsor, or pharmacy benefits manager. 90-590-243 ME. CODE R. § 1(I). **Third-Party Payer**: A state agency that pays for health care services or a health insurer, carrier, including a carrier that provides only administrative services for plan sponsors, nonprofit hospital, medical services organization, or managed care organization licensed in Maine. 90-590-243 ME. CODE R. § 1(AA).	Health care claims processors are required to submit a completed health care claims data set for all members who are Maine residents. The health care claims data set must include a member eligibility file containing records associated with each of the claims files reported: a medical claims file, a pharmacy claims file, and/or a dental claims file. The data set shall also include supporting definition files for payer specific provider specialty codes. 90-590-243 ME. CODE R. § 2. • *Medical Claims File.* A data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment information, and clinical diagnosis/procedure codes from all non-denied adjudicated claims for each billed service. 90-590-243 ME. CODE R. § 1(K).	Data is available in three levels (I, II, and III). 90-590-120 ME. CODE R. § 5. Level I data is de-identified data; Level II data is file-limited data; and Level III is direct patient identifiers. 90-590-120 ME. CODE R. § 6-8. Additionally, any request may include a request for the payer-assigned group ID number. All data that is not public data must be requested by application and be followed by entering into a data use agreement. 90-590-120 ME. CODE R. § 6-8. Any person may request information/data. 90-590-120 ME. CODE R. § 2(3). The Maine Health Data Organization, however, will create a page on its website

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payers. Maine also has a portal through which hospitals can submit hospital encounter data for all encounters inpatient and outpatient, as well as for their provider-based clinics. Data FAQs.		• *Pharmacy Claims File.* A data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment information, and national drug codes from all non-denied adjudicated claims for each prescription filled. 90-590-243 ME. CODE R. § 1(T). • *Dental Claims File.* A data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment information, and current dental terminology codes from all non-denied adjudicated claims for each billed service. 90-590-243 ME. CODE R. § 1(G). The frequency of such submissions will depend on the total number of members. • ≥ 2,000: Monthly • ≤ 2,000: Quarterly. 90-590-243 ME. CODE R. § 3(F). Exemption Third-party administrators and carriers acting as third party administrators for self-funded employee benefit plans regulated by ERISA are not required to submit data for members in such plans. 90-590-243 ME. CODE R. § 2. Nonetheless, any self-funded employee benefit plan regulated by ERISA may voluntarily submit completed healthcare data sets for Maine residents. 90-590-243 ME. CODE R. § 5. Additionally, if a health care claims processor, due to circumstances beyond its control, is temporarily unable to meet its submission requirements, a written request may be made to the Maine Health Data Organization for a waiver or extension. 90-590-243 ME. CODE R. § 7.	that lists the identity/address of all parties requesting data (including the level of the data requested and the purpose of the request). 90-590-120 ME. CODE R. § 10.
Maryland Medical Care Data Base	**Reporting Entity**: A payor or a third party administrator that is designated by the Maryland Health Care Commission to provide reports and data for the Medical Care Data Base. MD. ADMIN. CODE § 10.25.06.02(28). Such designation occurs when:	A reporting entity must submit the following information quarterly: • *Professional Services Data Report*. A report that contains data for each fee-for-service and capitated encounter provided by a health care practitioner or office facility. MD. ADMIN. CODE § 10.25.06.07.	The Maryland Health Care Commission is required to develop public-use data, summaries, and compilations of data for public disclosure. MD. ADMIN. CODE § 10.25.06.19.

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MD. ADMIN. CODE § 10.25.06.01 et seq.; MCDB Data Release	• A payor's coverage exceeds 1,000, as reported to the Maryland Insurance Administration. • A payor offers a qualified health plan, qualified dental plan, or qualified vision plan certified by the Maryland Health Benefit Exchange. • A payor is a health maintenance organization participating in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program. MD. ADMIN. CODE § 10.25.06.03(A). **Payor**: A payor includes: • An insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in Maryland. • A health maintenance organization that holds a certificate of authority in Maryland. • A third party administrator registered in Maryland. MD. ADMIN. CODE § 10.25.06.02(20).	• *Pharmacy Data Report*. A report that contains all pharmacy services provided to each Maryland resident insured under a fully insured contract or a self-insured contract, and to each non-Maryland resident insured under a Maryland contract. MD. ADMIN. CODE § 10.25.06.08. • *Provider Directory Report*. A report that contains information for each in-State Maryland practitioner or supplier, and for each out-of-State practitioner or supplier, that has served a Maryland resident or a non-Maryland resident under a Maryland contract. MD. ADMIN. CODE § 10.25.06.09. • *Institutional Services Data Report*. A report that contains all institutional health care services provided to each Maryland resident insured under a fully insured contract or self-insured contract, and each non-Maryland resident insured under a Maryland contract. MD. ADMIN. CODE § 10.25.06.10. • *Eligibility Data Report*. A report that contains information on the characteristics of each enrollee that is a Maryland resident insured under a fully insured contract or a self-insured contract, and that is a non-Maryland resident insured under a Maryland contract for services covered under each policy or contract issued by the reporting entity. MD. ADMIN. CODE § 10.25.06.11. • *Plan Benefit Design Report*. • *Dental Data Report*. • *Non-Fee-for-Service Medical Expenses Report*. MD. ADMIN. CODE § 10.25.06.05(A). For additional information on the submission of data, *see* the Maryland Data Submission Guide. <u>Exemptions</u> • A payor whose coverage does not exceed 1,000 does not qualify as a reporting entity as is not required to submit the required data/reports. • Private plan data for self-insured ERISA plans is also exempted due to the *Gobeille* decision. The standard analytic file contains only privately fully-insured and self-insured non-ERISA health	For the data to be released to a given individual or entity, they must be authorized to receive such data following an application process. MD. ADMIN. CODE § 10.25.06.06(B)(2); MCDB Data Release. Additionally, to ensure that confidential or privileged patient information is kept confidential, prior to disclosure of data that contains "directly or indirectly identifiable health information," as defined in HIPAA, a review must be conducted. MD. ADMIN. CODE § 10.25.06.06(C).

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		insurance plans for Maryland and non-Maryland residents. MCDB Data Release. Additionally, reporting entities may submit a written request asking for a 30 day extension to provide the required data or a complete waiver. MD. ADMIN. CODE §§ 10.25.06.16, 10.25.06.17.	
Massachusetts 957 CMR 8.00 et seq.; 957 CMR 5.00 et seq. ***The MA-APCD contains claims data submitted by payers. Massachusetts also has a portal through which hospitals can submit "case mix and charge" data.* 957 CMR 8.01. *Additionally, separate from the APCD requirements, payers are also required to report specific membership and financial data. 957 CMR 10.00 et seq.*	**Payer**: A private health care payer and a public health care payer. 957 CMR 8.02. **Private Health Care Payer**: A private entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. It includes a carrier authorized to transact accident and health insurance, a nonprofit hospital service corporation, a nonprofit medical service corporation, a dental service corporation, an optometric service corporation, a self-insured plan (to the extent allowable under federal law), a health maintenance organization, and third-party administrators. 957 CMR 8.02. **Public Health Care Payer**: The Medicaid program; any carrier or other entity that contracts with the office of Medicaid or the Commonwealth Health Insurance Connector to pay for or arrange for the purchase of health care services on behalf of individuals enrolled Medicare, or under the Connector Care Health Insurance program; the Group Insurance Commission; and any city or town with a population of more than 60,000 that has adopted certain provisions of Massachusetts law. 957 CMR 8.02.	Payers are required to submit data relating to medical claims, pharmacy claims, dental claims, member eligibility files, provider files, and benefit plan and product files. • *Member Eligibility File*. A file that includes data about a person who receives health care coverage from a payer, including but not limited to subscriber and member identifiers; member demographics; race, ethnicity and language information; plan type; benefit codes; enrollment start and end dates; and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators. 957 CMR 8.02. Payers must provide claims-line detail for all health care services provided to Massachusetts residents, whether or not the health care was provided within Massachusetts, including out-of-state residents of a Massachusetts-based employer or Massachusetts employment site, and out-of-state residents of a Massachusetts licensed health care payer. Such data shall include but is not limited to fully-insured and self-funded accounts, to the extent allowable under federal law governing health care provided by employers to employees, and all commercial medical products for all individuals and all group sizes. 957 CMR 8.03(2)(a). For additional information on the submission of data, *see* Massachusetts Bulletin 17-02 and the various submission guides. <u>Exemptions</u> A self-funded employee plan or third-party administrator/carrier providing claims administration services to a self-funded employee plan	Payers, providers, provider organizations, and researchers are permitted to request: • Summarized data reports containing aggregate and de-identified data (e.g., counts, totals, rates per thousand, etc.). 957 CMR 5.07. • De-identified data, provided the application establishes that the data will exclusively be used for the purposes of lowering total medical expenses, coordinating care, benchmarking, quality analysis and other research, administrative or planning purposes. 957 CMR 5.04. • Data with direct patient identifiers for treatment and coordination of care (to the extent permissible under state and federal laws protecting patient privacy and security). 957 CMR 5.05. • Other types of data. 957 CMR 5.06. Government agencies are permitted to request protected health information, provided they identify the public health purposes for which the data is sought and the security measures designed to protect the data from inadvertent/unauthorized disclosure. 957 CMR 5.03(2). All entities must make such requests in writing; they must be accompanied by an application; and, once approved, they will be followed by a data use agreement. 957 CMR 5.03-5.06.

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		is not required to submit data, but such data may be submitted on a voluntary basis. 957 CMR 8.03(2)(c). Additionally, an extension of time may be granted to payers for good cause. 957 CMR 8.05(3).	
Minnesota MINN. ADMIN. CODE § 4653.0100 et seq.; MINN. STAT. ANN. § 62U.04.	**Data Submitter**: A data submitter is defined to include: • A health plan company or third-party administrator that has covered individuals and that has paid a total of at least $3 million in health care claims for covered individuals during the previous calendar year. • A pharmacy benefit manager that has covered individuals and paid at least $300,000 in claims for covered individuals during the previous calendar year. MINN. ADMIN. CODE § 4653.0100(8). **Covered Individual**: A natural person who is a resident of Minnesota and is eligible to receive health care benefits under any policy, contract, certificate, evidence of coverage, rider, binder, or endorsement that provides for or describes health care coverage (unless excluded from the definition of health plan under Minnesota law). MINN. ADMIN. CODE § 4653.0100(4).	Data submitters are responsible for submission of enrollment data, encounter data elements and pricing data for all institutional and professional health care claims paid by the data submitter, and encounter data elements and pricing data for all pharmacy drug claims paid by the data submitter for each covered individual every six months. MINN. ADMIN. CODE §§ 4653.0200(B), 4653.0300(2). • *Enrollment Data*. Demographic information and other information relating to all covered individuals eligible to receive health care benefits. MINN. ADMIN. CODE § 4653.0100(9). • *Pricing Data*. The amount paid by a data submitter to a provider on a claim plus any amount owed by the covered individual, including prepayment, deductible, coinsurance, or co-payment. MINN. ADMIN. CODE § 4653.0100(15). • *Health Care Claims Data.* Information included in an institutional, professional, or pharmacy drug claim or equivalent encounter information transaction for a covered individual that is required under Minnesota law. MINN. ADMIN. CODE § 4653.0100(10). In practice, APCD data for Minnesota residents with health insurance includes: • All medical and health services insurance claims paid by a health plan company or TPA including commercial products and managed care data for Medicaid and Medicare. • Medicare fee for service data. • Medicaid and other state fee for service claims. Minnesota APCD FAQs (2015), at 2. Certain data, however, is not included. For example: • Hearing, dental, vision, or disability-only. • Auto medical or accident-only. • Insurance supplemental to liability.	Currently, access to the APCD is limited to staff at the Minnesota Department of Health or organizations working under contract with the Department to conduct research on its behalf. Minnesota APCD FAQs (2015), at 6-7.

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		• Long-term care or workers' compensation. • Medicare Supplemental and Medigap. • Veterans Affairs, Indian Health Service, Tricare. • Non-Minnesota residents. Minnesota APCD FAQs (2015), at 3. <u>Exemptions</u> • A data submitter may discontinue submitting health care claims data if it pays less than $1 million in health care claims for covered individuals for each of two consecutive calendar years. • A pharmacy benefit manager may discontinue submitting health care claims data if it pays less than $100,000 in health care claims for covered individuals for each of two consecutive calendar years. MINN. ADMIN. CODE § 4653.0300(7).	
New Hampshire N.H. REV. STAT. § 420-G:11; N.H. ADMIN. CODE § 4002.01 et seq.; N.H. ADMIN. R. § He-W 950.01 et seq.; NH CHIS FAQs	**Health Care Claims Data Sets**: Information consisting of or derived directly from member eligibility files; or medical, pharmacy, or dental claims files submitted by health care claims processors collected under New Hampshire Law. They include public use data sets and limited use data sets. N.H. ADMIN. R. § He-W 950.03(h); N.H. ADMIN. CODE § 4002.01(n). **Health Insurance Carriers/Third Party Administrators**: The data submission requirements apply with respect to claims data for all lives covered by: • A fully-insured health plan in any market in the state. • Any self-funded plan for state or municipal employees. • Any self-funded plan maintained by the university system of the state with respect to its employees or its students. • Any self-funded student health benefit plan maintained by an institution of higher education	Generally, all health insurance carriers and third party administrators must electronically provide a complete and accurate health care claims data set. N.H. ADMIN. CODE § 4005.01; N.H. REV. STAT. § 420-G:11(II)(a). • *Member Eligibility File*. A data file containing demographic information for each individual member eligible for medical, pharmacy, or dental benefits for one or more days of coverage at any time during the reporting month as well as any retrospective updates that correspond to previously submitted eligibility data. It should include benefits, attributed and associated effective periods. N.H. ADMIN. CODE § 4002.01(s). • *Medical Claims File*. A data file composed of service level remittance information for all adjudicated claims for each billed medical service provided to members, including data for services provided under alternative payment arrangements with zero paid amounts. N.H. ADMIN. CODE § 4002.01(q). • *Pharmacy Claims File*. A data file composed of service level remittance information from all adjudicated claims for each billed prescription provided to members, including data for services provided under alternative payment arrangements with zero paid amounts. N.H. ADMIN. CODE § 4002.01(u).	Public use data sets must be made available in public use files and provided to any person upon written request, except when otherwise prohibited by law. To receive a public use data set, a request form must be completed. N.H. ADMIN. R. § He-W 950.04(a). Limited use data sets, on the other hand, are only allowed to be released for purposes of research. Similarly, to request a limited use data set, an application must be submitted. N.H. ADMIN. R. § He-W 950.05(a). Neither data set will contain direct patient identifiers. N.H. ADMIN. R. § He-W 950.09(a). Moreover, the collection, storage, and release of health care data and statistical information that is subject to HIPAA is governed by the federal rules adopted thereunder. N.H. REV. STAT. § 420-G:11(II)(b).

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	which provides 4-year bachelor's degree programs and graduate or professional degree programs. • Any other self-funded employer-sponsored plan, when the employer has opted in writing to the submission of the data. N.H. REV. STAT. § 420-G:11(IV)-(V). **Carrier**: Any entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health services, or to administer on behalf of third-party payer, and includes an insurance company, a health maintenance organization, a nonprofit health services corporation, a dental benefits administrator, a third-party administrator or any other entity arranging for or providing health coverage, and Medicare Advantage plans. N.H. ADMIN. CODE § 4002.01(e). **Third Party Administrator**: Any persons licensed by the department that receives or collects charges, contributions or premiums for, or adjusts or settles claims for residents of the state, on behalf of a plan sponsor, health care services plan, dental services plan, nonprofit hospital or medical service organization, health maintenance organization or insurer. N.H. ADMIN. CODE § 4002.01(ad).	• *Dental Claims File.* A data file composed of service level remittance information for all adjudicated claims for each billed dental service provided to members, including data for services provided under alternative payment arrangements with zero paid amounts. N.H. ADMIN. CODE § 4002.01(g). • *Provider File.* A data file listing information about the service providers identified in the medical claims, pharmacy claims, and the dental claims file as servicing billing, prescribing, or primary providers. N.H. ADMIN. CODE § 4002.01(z). The frequency of such submissions will depend on the total number of members. • ≥ 10,000: Monthly • ≤ 9,999: Quarterly, provided the carrier or TPA does not meet the exclusion criteria under New Hampshire Law. N.H. ADMIN. CODE § 4004.01. All health carriers must also annually submit the Health Employer Data and Information Set. N.H. REV. STAT. § 420-G:11(II-a). For additional information on the submission of data, *see* New Hampshire Data Submission Manual. <u>Exemptions</u> • Carriers that do not offer any products on the health insurance exchange for residents of New Hampshire, and that did not cover more than 9,999 members in New Hampshire at any point in any medical, pharmacy or dental coverage class during the prior calendar year are not required to submit health care claims data files. N.H. ADMIN. CODE § 4005.02(a)(1). • Third-party administrators that did not cover more than 9,999 members in New Hampshire at any point in any medical, pharmacy or dental coverage class during the prior calendar year. N.H. ADMIN. CODE § 4005.02(a)(2). • Carriers and TPAs are not required to submit health care claims data about coverage that is not a part of a comprehensive medical insurance policy (e.g., specific disease, accident, injury, hospital	

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		indemnity, disability, long-term care, vision coverage, durable medical equipment, or blanket health insurance). N.H. ADMIN. CODE § 4005.02(c). • Following the *Gobeille* decision, the New Hampshire Insurance Department temporarily suspended enforcement of health claims data submission requirements under New Hampshire law. The state legislature then took action to clarify the applicability of the APCD provisions to data associated with the plans operated by self-funded employers. Since enactment of the new law, the Department of Insurance has resumed enforcement and issued updated, corresponding regulations. Bulletin 16-034-AB. Specifically, the new law creates an opt-in mechanism for self-funded private employers to instruct their claims.	
New York All Payer Database 10 NYCRR 350.1 et seq.; All Payer Database Guidance Manual	**Third-Party Health Care Payer**: An insurer, organization, or corporation licensed or certified under New York law; or an entity, such as a pharmacy benefits manager, fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system. Unless permitted by federal law, the term does not include self-insured health plans regulated by ERISA, although such plans that operate in New York State may choose to participate as a third-party health care payer. 10 NYCRR 350.1(k).	Third-party health care payers must submit complete, accurate, and timely APD data—i.e., covered person data, claims data, and any other data contained within standard transactions for Electronic Data Interchange of health care data. 10 NYCRR 350.1(b), 350.2(a). • *Covered Person Data*. Data related to covered persons, such as demographics, member identifiers, coverage periods, policy numbers, plan identifiers, premium amounts, and selected primary care providers. 10 NYCRR 350.1(e). • *Claims Data*. Claims data includes benefits and coverage data (e.g., cost-sharing provisions and coverage limitations and exceptions); health care provider network data (e.g., services offered, panel size, licensing/certification, National Provider Identifiers, demographics, locations, accessibility, office hours, languages spoken, and contact information); post-adjudicated claims data (i.e., data related to health care claims, including payment data, that has been adjudicated by a third-party health care payer); and other health care payment data (e.g., value based payment information). 10 NYCRR 350.1(c). A third-party health care payer may submit a written request for an extension, variance, or waiver of APD submission requirements. 10 NYCRR 350.2(h).	Per the All Payer Database Guidance Manual, the APD enables data analysis by a wide variety of stakeholders (including researchers, consumers, employers, providers, and payers). All Payer Database Guidance Manual, at 4, 6. Additionally, limited sets of identifiable APD data may be released to researchers and other entities serving a public interest purpose. All Payer Database Guidance Manual, at 6. Specifically, the Department of Health is permitted to release data in the following manner: • De-identified and/or aggregated APD data of a public use nature may be posted to a consumer-facing website. • APD data, including data with identifying data elements, may be released to a New York State agency or the federal government in a manner that appropriately safeguards the privacy, confidentiality, and security of the data. • APD data, including data with identifying data elements, may be released to other data users that have met the Department's requirements for maintaining security, privacy, and confidentiality

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			and have approved data use agreements with the Department. 10 NYCRR 350.3(b). Data users that request APD data that includes identifying elements are required to submit an application for such data. 10 NYCRR 350.1(d).
Oregon All Payer All Claims (APAC) OR. REV. STAT. § 442.464; OR. ADMIN. CODE § 409-025-0100 et seq.; APAC: An Overview; APAC FAQs.	**Mandatory Reporter**: The following entities/individuals qualify as mandatory reporters: • All carriers and licensed third-party administrators with calculated mean total lives of 5,000 or higher. • All PBMs. • All coordinated care organizations. • All reporting entities with Dual Eligible Special Needs Plans in Oregon. • All insurers providing coverage under Medicare. • All insurers offering a health benefits plan in Oregon's health insurance exchange. • All insurers providing group health insurance plans to PEBB and OEBB members. OR. ADMIN. CODE § 409-025-0110(1). **Voluntary Reporter**: A voluntary reporter is a reporting entity that does not qualify as a mandatory reporter but elects to participate via notification to the Oregon Health Authority in writing. OR. ADMIN. CODE § 409-025-0110(2). **Reporting Entity**: A reporting entity includes: • An insurer or fraternal benefit society required to have a certificate of authority to transact health insurance business in Oregon. • A health care service contractor that issues medical insurance in Oregon. • A third party administrator required to obtain a license.	Mandatory and voluntary reports are required to submit data files for all required lines of business on a quarterly basis. They may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business. Such data files must include: • Medical and pharmacy claims files (e.g., diagnoses, service utilization, and spending for medical and pharmacy services). • Eligibility file (i.e., medical enrollment information, such as basic demographic information on enrollees of commercial, Medicaid, and Medicare plans). • Medical provider file (e.g., provider identifiers, locations, and specialties). • Control file (i.e., billed and paid amounts, medical and pharmacy member months,). • Subscriber billed premiums. • Annual supplemental provider level APM summary. • Control totals for annual supplemental provider level APM summary. OR. ADMIN. CODE § 409-025-0120(1); APAC FAQs, at 3-4, 6. As listed in a regulatory overview document, this includes medical and pharmacy claims, non-claims payment summaries, member enrollment data, billed premium information, and provider information for Oregonians who receive coverage through commercial insurers as well as through public payers. APAC: An Overview, at 2. The layout, format, and coding requirements are described in appendices to the regulation. <u>Exemptions</u>	There are four types of data that may be released: summarized data, a public use data set, a limited use data set, and a custom data set. • Summarized data are generated by request only and show only counts or aggregated totals. They offer the lowest level of detail and do not contain protected health information or patient-level data. • The public use data set includes de-identified health information and claim-level data. OR. ADMIN. CODE § 409-025-0160(3). • A limited use data set includes protected health information from which certain direct identifiers have been removed. Limited data sets may be disclosed only for purposes allowed by state and federal regulations, including research, public health, and health care operations. OR. ADMIN. CODE § 409-025-0160(4). • Custom data sets may be disclosed for purposes allowed by state and federal regulations, including research, public health, and health care operations. OR. ADMIN. CODE § 409-025-0160(5); APAC: An Overview, at 2, 15-16. To receive any of the above data, a requester must complete an application. Additionally, the Oregon Health Authority and applicable contractors perform data analyses and publish data and reports that serve the public's interest. OR. ADMIN. CODE § 409-025-0170(1).

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	• A pharmacy benefit manager or fiscal intermediary, or other person that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service. • A coordinated care organization. • An insurer providing coverage funded under Medicare, subject to approval by the United States Department of Health and Human Services. OR. REV. STAT. § 442.464; OR. ADMIN. CODE § 409-025-0100(81). **Required Lines of Business**: Required lines of business include Medicare (parts C and D), Medicaid, individual, small employer health insurance, large group, associations and trusts, PEBB and OEBB group health insurance plans, and self-insured plans not subject to ERISA). OR. ADMIN. CODE § 409-025-0110(3)(a). **Voluntary Lines of Business**: Voluntary lines of business include self-insured plans subject to ERISA. OR. ADMIN. CODE § 409-025-0110(3)(b). **Excluded Lines of Business**: Excluded lines of business include: accident policy, dental insurance, disability policy, hospital indemnity policy, long-term care insurance, Medicare supplemental insurance, specific disease policy, stop-loss plans, student health policy, vision-only insurance, and workers' compensation. OR. ADMIN. CODE § 409-025-0110(3)(c).	• A carrier or licensed TPA with fewer than 5,000 calculated mean total lives does not qualify as a mandatory reporter and is not required to submit the requisite data files. • Insurance coverage providing benefits for excluded lines of business. • Data on insured individuals or other populations who pay out-of-pocket for their health care are not included; nor is data on individuals insured through certain federal programs such as Tricare, the Federal Employees Health Benefits Program, the Indian Health Service, or the Department of Veterans Affairs. APAC FAQs, at 4. • Due to the Supreme Court's ruling in *Gobeille*, self-insured ERISA plans are exempt from mandatory reporting, though the APCD welcomes voluntary data reporting from self-insured ERISA plans. APAC FAQs, at 5. Additionally, the Oregon Health Authority may grant a waiver, deadline extension, or exception to the reporting requirements. OR. ADMIN. CODE § 409-025-0140(1).	The Oregon Health Authority is required to comply with all relevant state and federal data privacy, security, and antitrust regulations, including HIPAA, when sharing data from the APCD.
Rhode Island R.I. REG. § 1.1 et seq., R.I. GEN. L.	**Insurer**: Any entity subject to the insurance laws and regulations of Rhode Island, that contracts or offers to contract to provide, deliver, arrange for, pay for, or	Insurers are required to submit a health care data set either monthly or quarterly, whether or not the health care was provided within Rhode Island. Specifically, the health care data set must include: medical	Data is available to researchers, providers, health insurers, state agencies, and other qualified organizations or individuals who are looking to improve, evaluate, or otherwise measure healthcare provided to Rhode

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§ 23-17.17-9 et seq.; HealthFacts RI FAQs	reimburse any of the costs of health care services, including, without limitation: • An insurance company offering accident and sickness insurance, a health maintenance organization. • A nonprofit hospital or medical service corporation. • Any other entity providing a plan of health insurance or health benefits. A third-party payer, third-party administrator, or Medicare or Medicaid health plan sponsor is also deemed to be an insurer. R.I. REG. § 1.18	claims files, pharmacy claims files, member eligibility files, and provider files. R.I. REG. § 4.1, 4.3; R.I. GEN. L. § 23-17.17-10(a). • *Medical Claims File.* All submitted and non-denied adjudicated claims for each billed service paid by an insurer on behalf of a member regardless of where the service was provided. This data file includes but is not limited to service level remittance information including, but not limited to, member encrypted unique identifier, provider information, charge/payment information, and clinical diagnosis/procedure codes. R.I. REG. § 1.19. • *Pharmacy Claims File.* A data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment information, and national drug codes from all submitted and non-denied adjudicated claims for each prescription filled. R.I. REG. § 1.25. • *Member Eligibility File.* A data file composed of demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month. R.I. REG. § 1.21. • *Provider File.* A dataset that contains information that will uniquely identify health care providers and allow retrieval of related information from eligibility, medical and pharmacy claims files. R.I. REG. § 4.3(d). The information system is not permitted to collect any data that contains direct personal identifiers (e.g., information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number and social security number). R.I. GEN. L. § 23-17.17-10(b). Finally, the collection, storage and release of health care data and statistical information that is subject to the federal requirements of HIPAA. All insurers that collect the health employer data and information set (HEDIS) must annually submit the HEDIS information and such other relevant industry quality standard measures. R.I. GEN. L. § 23-17.17-11(b)-(c). For additional information on the submission of data, *see* Rhode Island Data Submission Guide.	Islanders. Data is also available free of charge to consumers through public reports. R.I. GEN. L. § 23-17.17-11(e); HealthFacts RI FAQs. Different data products are available upon request. For example, summary data tables and reports are available to the public free of charge. They focus on key health care issues. Standard claims extracts are pre-built, claims-line level extracts with individual member detail that may be used for statistical and other complex analyses. To receive such information, an application is required. As part of the application, requesters must justify why claims-level detail is necessary for their project. Requesters must pay a fee, sign a data use agreement, and be approved by the Director of the Department of Health to receive standard claims extracts. Finally, custom requests are available. These may include custom aggregated reports, or custom extracts. HealthFacts RI FAQs; R.I. REG. § 7.

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		<u>Exemptions</u>
		• An insurer that on January 1 of a reporting year with less than 3,000 enrolled or covered members.
		• Insurance coverage providing benefits for
		  ○ Hospital confinement indemnity.
		  ○ Disability income.
		  ○ Accident only.
		  ○ Long-term care.
		  ○ Medicare supplement.
		  ○ Limited benefit health insurance.
		  ○ Specified disease indemnity.
		  ○ Sickness or bodily injury or death by accident or both.
		  ○ Other limited benefit policies. R.I. GEN. L. § 23-17.17-9(f); R.I. REG. § 2.3.
		• Since the Supreme Court decision in *Gobeille*, insurers are no longer required to submit self-insured ERISA plans' data to Rhode Island's APCD. The Rhode Island APCD Team is working with insurers and self-insured employers to encourage continued submission of self-insured data to HealthFacts RI. HealthFacts RI FAQs.	

Tennessee TENN. CODE ANN. §§ 56-2-125, 71-5-152; TENN. ADMIN. CODE § 0780-01-79-.01 et seq. ***Currently inactive. The Office of the Attorney General issued an opinion*	**Health Insurance Issuer**: An entity subject to the insurance laws of this state, or subject to the jurisdiction of the Commissioner of the Tennessee Department of Commerce and Insurance, that contracts or offers to contract to provide health insurance coverage, including but not limited to: • An insurance company. • A health maintenance organization. • A nonprofit hospital and medical service corporation. It also means a pharmacy benefits manager, a third party administrator, and a rural health benefit program. TENN. ADMIN. CODE § 0780-01-79.02(11).	Each health insurance issuer is required to submit a completed health care claims data set for all residents of Tennessee on a monthly basis. The health care claims data set shall include member eligibility files, a medical claims file, and a pharmacy claims file. TENN. ADMIN. CODE §§ 0780-01-79-.03(1), 0780-01-79-.05; TENN. STAT. ANN. § 56-2-125(f)(1)(A). • *Member Eligibility File.* A data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month. TENN. ADMIN. CODE § 0780-01-79.02(15). • *Medical Claims File.* A data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member	The APCD is accessible by: • The Department of Finance and Administration. • The Department of Health. • The Department of Mental Health and Substance Abuse Services. • The Department of Intellectual and Developmental Disabilities. • Other departments of the state. TENN. CODE ANN. § 71-5-152(a). The use of the data from the APCD is subject to restrictions under HIPAA and other applicable privacy laws and policies. TENN. CODE ANN. § 56-2-125(d)(1).

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in 2016 in response to the Gobeille decision. It concluded that TENN. CODE ANN. *§ 56-2-125 is unconstitutional following the decision and, as such, the applicable regulatory agencies are allowed to stop enforcement of this section.* Attorney General Opinion 16-42.		demographics; provider information; charge/payment information; and clinical diagnosis/procedure codes. TENN. ADMIN. CODE § 0780-01-79.02(13). • *Pharmacy Claims File.* A data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to member demographics; provider information; charge/payment information; and national drug codes. TENN. ADMIN. CODE § 0780-01-79.02(17). Additionally, all insurers that collect the health employer data and information set (HEDIS) must annually submit the HEDIS information and such other relevant industry quality standard measures. TENN. CODE ANN. § 56-2-125(f)(3). <u>Exemptions</u> • Health insurance issuers that are not PBMs and that paid a total of less than $5 million for covered residents of Tennessee during the previous calendar year are not required to submit their health care claims data set. TENN. ADMIN. CODE § 0780-01-79-.03(8). • PBMs that paid a total of less than $1 million for covered residents of Tennessee during the previous calendar year are not required to submit their health care claims data set. TENN. ADMIN. CODE § 0780-01-79-.03(9). • Group health plans are exempt from the data reporting requirements to the extent that they do not use health insurance issuers to administer health benefits. TENN. ADMIN. CODE § 0780-01-79-.05(4). For additional information on the required elements for a data submission, *see* TENN. ADMIN. CODE §§ 0780-01-79-.03(4), 0780-01-79-.04.	
Utah	**Data Supplier**: A health care facility, health care provider, self-funded employer, third-party payor, health maintenance organization, or government	Each carrier is required to submit health care claims data on a monthly basis for each covered person where Utah is the covered person's primary residence, regardless of where the services are provided. UTAH ADMIN. CODE § 428-15-3. Claims data includes eligibility, medical	Data received from a data supplier may be disclosed. First, the Office of Health Care Statistics within the Utah Department of Health may prepare reports relating to

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UTAH CODE ANN. § 31A-30-302(4)(a); ***Utah's regulations also impose data reporting requirements on health care facilities for ambulatory surgery data; health plan enrollees for satisfaction data; and performance measures.* UTAH ADMIN. CODE §§ 428-10-4, 428-13-3, 428-12-4.	department which could reasonably be expected to provide health data. UTAH CODE ANN. § 26-33a-102(3). **Carrier**: A carrier includes any of the following: • An insurer engaged in the business of health care or dental insurance in Utah. • A business under an administrative services organization or administrative services contract arrangement. • A third-party administrator licensed in Utah that collects premiums or settles claims of residents of the state for health care insurance policies or health benefit plans. • A governmental plan that provides health care benefits. • A program funded or administered by Utah for the provision of health care services, including Medicaid, the Utah Children's Health Insurance Program, and the medical assistance programs, or any entity under a contract with the Utah Department of Health to serve clients under such a program. • A non-electing church plan that provides health care benefits. • A licensed professional employer organization acting as an administrator of a health care insurance plan. • A health benefit plan funded by a self-insurance arrangement. • The Public Employees' Benefit and Insurance Program. • A pharmacy benefit manager. UTAH ADMIN. CODE § 428-2-3(d).	claims, pharmacy claims, and provider data. Utah Data Submission Guide, at 5. Additionally, all carriers that collect the health employer data and information set (HEDIS) must annually submit the HEDIS information and such other relevant industry quality standard measures. UTAH ADMIN. CODE § 428-13-3. For additional information on the submission of data, *see* Utah Data Submission Guide. Exemptions Exemptions or extensions may be granted from reporting requirements to data suppliers under certain circumstances (e.g., when the supplier demonstrates that compliance imposes an unreasonable cost). UTAH ADMIN. CODE § 428-2-10.	health care cost, quality, access, health promotion programs, or public health. Second, the Office may approve the disclosure of a public use data set or release identified data for research and statistical purposes upon receipt of a written request for such data. UTAH ADMIN. CODE § 428-2-8 There are, however, restrictions on the release of reports that compare/identify health care providers or data suppliers. UTAH CODE ANN. § 26-33a-107.
Vermont	**Mandated Reporter**: A health insurer with 200 or more enrolled or covered members in each month during a calendar year, including both Vermont	Mandated reporters are required to submit health care claims data for all members who are Vermont residents and all non-residents who received covered services provided by Vermont health care providers or	The requirements, procedures, and conditions under which certain persons may have access to health care claims data sets and related information will depend

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VT. STAT. ANN. § 9410; VT. ADMIN. CODE § 4-5-11:3 et seq.	residents and any non-residents receiving covered services provided by Vermont health care providers and facilities. VT. ADMIN. CODE § 4-5-11:3(Ab). **Health Insurer**: Any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. VT. ADMIN. CODE § 4-5-11:3(X); VT. STAT. ANN. §§ 9402(8), 9410(j)(1). It also includes: • Any health benefit plan offered or administered by or on behalf of Vermont or an agency or instrumentality of the state. • Any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government. VT. STAT. ANN. § 9410(j)(1). **Voluntary Reporter**: Any entity other than a mandated reporter, including any health benefit plan offered or administered by or on behalf of the federal government where such plan, with the agreement of the federal government, voluntarily submits data for inclusion in the database on such terms as may be appropriate. VT. ADMIN. CODE § 4-5-11:3(As). **Department**: The Department of Banking, Insurance, Securities, and Health Care Administration. VT. ADMIN. CODE § 4-5-11:3(A).	facilities. VT. ADMIN. CODE § 4-5-11:5. The frequency of such submissions will depend on the total number of members. • ≥ 2,000: Monthly • 500-1,999: Quarterly • 200-499: Annually • ≤ 200: N/A. VT. ADMIN. CODE § 4-5-11:6(I). The health care claims data submitted shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file and a pharmacy claims file. The data submitted must also include supporting definition files for payer specific provider specialty taxonomy codes and procedure and/or diagnosis codes. VT. ADMIN. CODE § 4-5-11:5. • *Medical Claims File.* A data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health. VT. ADMIN. CODE § 4-5-11:3(Ac). • *Pharmacy Claims File*. A data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics; provider information; charge/payment information; and national drug codes. VT. ADMIN. CODE § 4-5-11:3(Ak). • *Member Eligibility File.* A data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month. VT. ADMIN. CODE § 4-5-11:3(Ae). Additionally, all insurers that collect the health employer data and information set (HEDIS) must annually submit the HEDIS information and such other relevant industry quality standard measures. VT. STAT. ANN. § 9410(g)(2)(a). For additional information on the submission of data, *see* VT. ADMIN. CODE § 4-5-11:5; and the Vermont Data Submission Guide.	upon the requestor and the characteristics of the particular information requested. VT. ADMIN. CODE § 4-5-11:8. For example: • "Unrestricted" Data Elements are available for general use and public release. • "Restricted" Data Elements are not available for use and release outside the Department except as part of a Limited Use Research Health Care Claims Data Set approved by the commissioner. • "Unavailable" Data Elements are not available for release or use outside the Department in any data set or disclosed in publicly released reports in any circumstance. VT. ADMIN. CODE § 4-5-11:8(A). To determine the application requirements, fees, and the accessible data for each required file, *see* VT. ADMIN. CODE § 4-5-11:8-9 – Appendix J. Additionally, the collection, storage, and release of health care data and statistical information that are subject to HIPAA will be governed exclusively by the HIPAA data collection regulations. VT. STAT. ANN. § 9410(h)(2). To the extent allowed by HIPAA, however, the data will be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size. VT. STAT. ANN. § 9410(h)(3)(B). Finally, notwithstanding HIPAA or any other provisions of law, the APCD will not publicly disclose any data that contain direct personal identifiers (e.g., information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address,

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		Voluntary reporters, on the other hand, may submit data with the permission of the Commissioner of the Department of Banking, Insurance, Securities, and Health Care Administration. VT. ADMIN. CODE § 4-5-11:4(E). Exemptions • A health insurer with fewer than 200 members during a calendar year is not a mandated reporter and therefore is exempt from reporting obligations. • Self-insured ERISA plans are exempt from mandatory reporting.	email address, telephone number, and social security number). VT. STAT. ANN. § 9410(h)(3)(D).
Virginia VA. CODE ANN. § 32.1-276:7.1; Overview of the Virginia APCD.		Virginia's APCD is a voluntary program with specific requirements of participating data submitters and certain restrictions on how the de-identified data may be used. Overview of the Virginia APCD. The APCD may collect paid claims data for covered benefits from entities electing to participate as data suppliers. Currently, such data suppliers include commercial and public insurance carriers, which include, at this time: the Department of Medical Assistance Services and nine commercial insurance carriers (i.e., Aetna, Anthem BCBS, Carefirst, CIGNA, INTotal Health, Kaiser Permanente, Optima Health, United Health Care, and Virginia Premier). Overview of the Virginia APCD; VA. CODE ANN. § 32.1-276.7:1(B). Information collected includes: • Hospital discharge data. • Financial and operational data from hospitals, nursing facilities and surgical centers. • Certificate of need data. • Health care prices from health insurance companies. • HMO cost and quality information and outpatient survey data. Overview of the Virginia APCD. The ACPD's collection of such data must be pursuant to a data submission and use agreement. VA. CODE ANN. §§ 32.1-276.4, 32.1-276.7:1(C).	Virginia Health Information—a nonprofit organization that manages the APCD—evaluates requests for APCD data and develops a price quote based on the nature of the request. VHI then presents each request to the APCD Advisory Committee for approval. If approved, data is provided to the requester in the desired format. Overview of the Virginia APCD. The statute specifically requires the APCD to include the reporting of data that health care purchasers, including employers and consumers, may use to compare quality and efficiency of health care, including development of information on utilization patterns and information that permits comparison of providers statewide between and among regions of the Commonwealth. VA. CODE ANN. § 32.1-276.7:1(E)(2).

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		Exceptions The following kinds of coverage are excluded from the APCD at this time: • Workers' compensation. • Medicare fee for service. • TRICARE and the Veterans Health Administration. • Federal Employees Health Benefit Plan. Overview of the Virginia APCD.	
Washington WASH. REV. CODE § 43.371.010 et seq.; WASH. ADMIN. CODE § 82-75-010 et seq.	**Data Supplier**: A carrier, third-party administrator, or a public program that provides claims data; and a carrier or any other entity that provides claims data to the database at the request of an employer-sponsored self-funded health plan or Taft-Hartley trust health plan. WASH. REV. CODE § 43.371.010(4). This includes the state Medicaid program, public employees' benefits board programs, all health 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. WASH. REV. CODE § 43.371.030. **Direct Patient Identifier**: 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. WASH. REV. CODE § 43.371.010(7).	Each data supplier must submit data and claim files on a quarterly basis. WASH. REV. CODE § 43.371.030; WASH. ADMIN. CODE § 82-75-050(3). A data file is a data set composed of member or provider information including, but not limited to, member eligibility and enrollment data and provider data with necessary identifiers. WASH. ADMIN. CODE § 82-75-020. • *Member Eligibility and Enrollment Data*. A data set containing data about Washington covered persons who receive health care coverage from a payer for one or more days of coverage during the reporting period including, but not limited to, subscriber and member identifiers, member demographics, plan type, benefit codes, and enrollment start and end dates. WASH. ADMIN. CODE § 82-75-020. • *Provider Data with Necessary Identifiers*. A data file containing information about health care providers that submitted claims for providing health care services, equipment or supplies, to subscribers or members and such other data as required by the data submission guide. WASH. ADMIN. CODE § 82-75-020. A claim file is a data set composed of health care service level remittance information for all nondenied adjudicated claims under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, covered medical services files, pharmacy files and dental files. WASH. ADMIN. CODE § 82-75-020.	Claims or other data from the database will be available for retrieval in processed form to public and private requesters, provided the requester submits a data request application that contains the following information: • The identity of any entities that will analyze the data in connection with the request; • The stated purpose of the request and an explanation of how the request supports the purpose and goals of the APCD; • A description of the proposed methodology; • The specific variables requested and an explanation of how the data is necessary to achieve the stated purpose of the request; • How the requester will ensure all requested data is handled in accordance with the privacy and confidentiality protections required under state and federal law; • The method by which the data will be stored, destroyed, or returned to the lead organization at the conclusion of the data use agreement; • 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 • Consent to the penalties associated with the inappropriate disclosures or uses of direct patient identifiers, indirect patient identifiers, or proprietary

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	Indirect Patient Identifier: A data variable that may identify an individual when combined with other information. WASH. REV. CODE § 43.371.010(9). **Proprietary Financial Information**: 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, and a specific payer, or internal fee schedule or other internal pricing mechanism of integrated delivery systems owned by a carrier. WASH. REV. CODE § 43.371.010(12). **Unique Identifier**: 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. WASH. REV. CODE § 43.371.010(13).	• *Covered Medical Services File.* A data set composed of service level remittance information for all nondenied adjudicated claims for Washington covered persons that are authorized under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, member demographics, provider information, charge and payment information including facility fees, clinical diagnosis codes and procedure codes. WASH. ADMIN. CODE § 82-75-020. • *Pharmacy Claims File.* A data set containing service level remittance information for all nondenied adjudicated claims for pharmacy services for Washington covered persons including, but not limited to, enrolled member demographics, provider information, charge and payment information including dispensing fees, and national drug codes. WASH. ADMIN. CODE § 82-75-020. • *Dental Claims File.* A data set composed of service level remittance information for all nondenied adjudicated claims for dental services for Washington covered persons including, but not limited to, member demographics, provider information, charge and payment information including facility fees, and current dental terminology codes as defined by the American Dental Association. WASH. ADMIN. CODE § 82-75-020. Employer-sponsored self-funded health plans and Taft-Hartley trust health plans may voluntarily provide claims data to the database on a quarterly basis. WASH. REV. CODE § 43.371.030; WASH. ADMIN. CODE § 82-75-050(3). <u>Exemptions</u> A waiver of reporting requirements or an extension of time to a reporting requirement deadline may be granted based on extenuating circumstances. WASH. ADMIN. CODE § 82-75-080.	financial information. WASH. REV. CODE § 43.371.050(1). Additional requirements for a application can be found at WASH. ADMIN. CODE § 82-75-210. Beyond the data request application, data requesters must also submit data management plans that provide detailed information including, but not limited to, the following: • Physical possession and storage of the data files. • Data sharing, electronic transmission and distribution. • Data reporting and publication. • Completion of project tasks and data destruction. WASH. ADMIN. CODE § 82-75-220. Finally, certain entities may be restricted in the types of data to which they may have access (e.g., different requesters are entitled to different levels of access to and use of different data from the database). For example: • Claims or other data that include proprietary financial information, direct patient identifiers, indirect patient identifiers, unique identifiers, or any combination thereof may be released only to the extent such information is necessary to achieve the purpose of the database to researchers with approval of an institutional review board upon receipt of a signed data use and confidentiality agreement with the lead organization. • Claims or other data that do not contain direct patient identifiers, but that may contain proprietary financial information, indirect patient identifiers, unique identifiers, or any combination thereof may be released to federal, state, and local government agencies. • Claims or other data that do not contain proprietary financial information, direct patient identifiers, or any combination thereof, but that may contain

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			indirect patient identifiers, unique identifiers, or a combination thereof may be released to agencies, researchers, and other approved entities. • Claims or other data that do not contain direct patient identifiers, indirect patient identifiers, proprietary financial information, or any combination thereof may be released upon request. WASH. REV. CODE § 43.371.050(4). In many of the above, upon approval of a request for data, the requester must sign a data use agreement that contains, among other things, a confidentiality statement. WASH. ADMIN. CODE § 82-75-240.
West Virginia W.V. CODE ANN. § 33-4A-1 et seq.; W.V. CODE R. § 114A-1-1 et seq.	**Health Care Payer**: Any entity that pays or administers the payment of health insurance claims to providers in this state, including accident and sickness insurers; nonprofit hospital service corporations, medical service corporations and dental service organizations; nonprofit health service corporations; prepaid limited health service organizations; health maintenance organizations; and government payers (e.g., Medicaid, Medicare and the public employees insurance agency). The term also includes any third-party administrator including any pharmacy benefit manager, that administers a fully-funded or self-funded plan. W.V. CODE ANN. § 33-4A-1(e); W.V. CODE R. § 114A-1-2(2.11). **Data**: The data elements from enrollment and eligibility files, specified types of claims, and reference files for date elements not maintained in formats consistent with national coding standards. W.V. CODE ANN. § 33-4A-1(c); W.V. CODE R. § 114A-1-2(2.7).	In general, any health care payer is presumed to be a "data submitter" for a given calendar year if it issued a policy/certificate under which it paid medical and/or pharmacy claims to a provider in West Virginia in the immediately preceding calendar year. W.V. CODE R. § 114A-1-3(3.1.a). Similarly, any TPA is presumed to be a data submitter for a given calendar year if it administered the payment of medial and/or pharmacy claims on behalf of a self-funded plan in the immediately preceding calendar year. W.V. CODE R. § 114A-1-3(3.1.b). Each data submitter is required to submit a "completed health care claims data set" (i.e., a member eligibility file, a medical claims file, and a pharmacy claims file) for all members who are West Virginia residents to the commissioner or an entity designated by the commissioner. W.V. CODE ANN. § 33-4A-4(a); W.V. CODE R. §§ 114A-1-2(2.9), 114A-1-5(5.1). • *Member Eligibility File.* A data file that contains demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting period. W.V. CODE R. § 114A-1-2(2.15). • *Medical Claims File.* A data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics; provider information; charge/payment information; clinical diagnosis/procedure codes; and data related to behavioral,	Data submitted to and retained by the APCD may be a resource for insurers, researchers, employers, providers, purchasers of health care, consumers, and state agencies. W.V. CODE ANN. § 33-4A-4(c)(2). Data submitted to and retained by the APCD must be available as a resource for the commissioner, chair, and secretary to continuously review health care utilization, expenditures, and performance in the state and to enhance the ability of consumers to make informed and cost-effective health care decisions. W.V. CODE ANN. § 33-4A-4(c)(1). The data that contains personal identifiers (i.e., information relating to an individual member or insured that can be used to identify, locate, or contact a particular individual member or insured, including name, address, social security number, email address, telephone number, etc.) may <u>not</u> be disclosed. The commissioner, chair, and secretary may approve access to other data elements not prohibited from disclosure, as well as synthetic or created unique identifiers, for use by researchers, including government

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	Commissioner: The West Virginia Insurance Commissioner. W.V. CODE ANN. § 33-4A-1(b); W.V. CODE R. § 114A-1-2(2.6). **Chair**: The chairperson of the West Virginia Health Care Authority. W.V. CODE R. § 114A-1-2(2.5). **Secretary**: Secretary of the West Virginia Department of Health and Human Resources. W.V. CODE ANN. § 33-4A-1(g); W.V. CODE R. § 114A-1-2(2.20).	mental health, or substance abuse treatment. W.V. CODE R. § 114A-1-2(2.13). • *Pharmacy Claims File.* A data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to member demographics; provider information; charge/payment information; and national drug codes. W.V. CODE R. § 114A-1-2(2.19). Certain data, however, is not subject to these reporting requirements, including claims under policies providing coverage for only: • Accident, disability or a combination of both; • Liability insurance or coverage issued as a supplement to liability insurance; • Credit only insurance; • Coverage for on-site clinics; or • Similar insurance where medical benefits are secondary or incidental to other insurance benefits; and certain benefits if provided under a separate policy or certificate, including: • Limited scope dental or vision; • Long-term care, nursing home care, home health care, community-based care, or any combination thereof; • Coverage for only a specified disease or illness; or • Hospital indemnity or other fixed indemnity insurance. W.V. CODE R. § 114A-1-3(3.3). <u>Exemptions</u> • Health care payers that paid or administered the payment of health insurance claims in West Virginia for less than 500 covered lives in the previous calendar year are exempt from the reporting requirements. W.V. CODE ANN. § 33-4A-4(a); W.V. CODE R. §§ 114A-1-2(2.9), 114A-1-3(3.2.a). • Payers of benefits under Medicare supplemental policies are categorically exempt from submitting data associated with claims made under such policies unless they are included on a list of data submitters published on the Commissioner's website. W.V. CODE R. § 114A-1-3(3.2.d).	agencies, with established protocols for safeguarding confidential or privileged information. W.V. CODE ANN. § 33-4A-4(d).

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		Additionally, the commissioner, secretary, and chair may grant an exemption for cause to any presumed data submitter/class of presumed data submitters from all or some of the requirements (e.g., the increased cost or difficulty in complying with the submission requirements or the marginal value of the data that would be reported by the exempt payers). W.V. CODE R. §§ 114A-1-3(3.2.c), 114A-1-5(5.2).	