



House of Representatives

General Assembly

File No. 11

February Session, 2010

Substitute House Bill No. 5004

House of Representatives, March 11, 2010

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING TRANSPARENCY IN HEALTH INSURANCE CLAIMS DATA.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

- 1 Section 1. (NEW) (*Effective July 1, 2010*) (a) As used in this section:
- 2 (1) "Claims paid" means the amounts paid for the covered
3 employees of an employer by an insurer, health care center, hospital
4 service corporation, medical service corporation or other entity as
5 specified in subsection (b) of this section for medical services and
6 supplies and for prescriptions filled, but does not include expenses for
7 stop-loss coverage, reinsurance, enrollee educational programs or
8 other cost containment programs or features, administrative costs or
9 profit.
- 10 (2) "Employer" means any town, city, borough, school district,
11 taxing district or fire district employing more than fifty employees.
- 12 (3) "Utilization data" means (A) the aggregate number of procedures

13 or services performed for the covered employees of the employer, by
14 practice type and by service category, or (B) the aggregate number of
15 prescriptions filled for the covered employees of the employer, by
16 prescription drug name.

17 (b) Each insurer, health care center, hospital service corporation,
18 medical service corporation or other entity delivering, issuing for
19 delivery, renewing, amending or continuing in this state any group
20 health insurance policy providing coverage of the type specified in
21 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
22 statutes shall:

23 (1) Disclose to an employer sponsoring such policy, upon request by
24 such employer, the following information for the most recent thirty-
25 six-month period or for the entire period of coverage, whichever is
26 shorter, ending not more than sixty days prior to the date of the
27 request, in a format as set forth in subdivision (3) of this subsection:

28 (A) Complete and accurate medical, dental and pharmaceutical
29 utilization data, as applicable;

30 (B) Claims paid by year, aggregated by practice type and by service
31 category, each reported separately for in-network and out-of-network
32 providers, and the total number of claims paid;

33 (C) Premiums paid by such employer by month; and

34 (D) The number of insureds by coverage tier, including, but not
35 limited to, single, two-person and family including dependents, by
36 month;

37 (2) Include in such requested information specified in subdivision
38 (1) of this subsection only health information that has had identifiers
39 removed, as set forth in 45 CFR 164.514, is not individually
40 identifiable, as defined in 45 CFR 160.103, and is permitted to be
41 disclosed under the Health Insurance Portability and Accountability
42 Act of 1996, P.L. 104-191, as amended from time to time, or regulations
43 adopted thereunder; and

44 (3) Disclose such requested information (A) in a written report, (B)
 45 through an electronic file transmitted by secure electronic mail or a file
 46 transfer protocol site, or (C) through a secure web site or web site
 47 portal that is accessible by such employer.

48 Such insurer, health care center, hospital service corporation, medical
 49 service corporation or other entity shall not be required to provide
 50 such information to the employer more than once in any twelve-month
 51 period.

52 (c) Any information disclosed to an employer in accordance with
 53 this section shall be confidential by law and privileged and shall not be
 54 subject to disclosure under section 1-210 of the general statutes, subject
 55 to subpoena, or subject to discovery or be admissible in evidence in
 56 any private civil action, except that an employee organization, as
 57 defined in section 7-467 of the general statutes, that is the exclusive
 58 bargaining representative of the employees of such employer shall be
 59 entitled to receive claim information from such employer in order to
 60 fulfill its duties to bargain collectively pursuant to section 7-469 of the
 61 general statutes.

62 (d) Information disclosed to an employer pursuant to this section
 63 shall be used by such employer only for the purposes of obtaining
 64 competitive quotes for group health insurance or to promote wellness
 65 initiatives for the employees of such employer.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2010	New section

Statement of Legislative Commissioners:

In section 1(a)(1), "or governmental entity" was deleted for internal consistency, and in section 1(b)(3)(C), "the employer insured by such insurer, health care center, hospital service corporation, medical service corporation or other entity." was changed to "such employer.", for clarity.

INS *Joint Favorable Subst.-LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill, which requires health insurance entities to disclose to certain employers specific claims data, does not result in a fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 5004

AN ACT CONCERNING TRANSPARENCY IN HEALTH INSURANCE CLAIMS DATA.

SUMMARY:

This bill requires an insurer or similar entity to disclose to an employer certain information about its group insurance policy. It defines “employer” as a town; city; borough; or school, taxing, or fire district that has more than 50 employees. The information relates to services used, claims paid, premiums paid, and the number of people covered under the policy.

The bill requires the insurer or entity to provide the information (1) at the employer’s request, (2) for the shorter of the most recent 36 months or entire coverage period ending within 60 days before making the request, and (3) in a specified format. It specifies that the insurer does not have to provide information more than once in a 12-month period.

Under the bill, information disclosed to an employer is (1) confidential and privileged, (2) exempt from disclosure under the Freedom of Information Act, (3) inadmissible as evidence in a private lawsuit, and (4) not subject to subpoena or discovery. The bill does not prohibit the employer from providing claim information to a collective bargaining unit to fulfill its statutory duties.

The bill requires an employer to use information it receives only for the purposes of obtaining competitive quotes for group insurance or to promote wellness initiatives for employees.

EFFECTIVE DATE: July 1, 2010

APPLICABILITY OF BILL

The bill applies to each insurer, health care center (i.e., HMO), hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues any group health insurance policy in Connecticut that covers (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

INFORMATION AN INSURER MUST DISCLOSE

The bill requires the insurer or entity to disclose, upon an employer's request:

1. complete and accurate medical, dental, and pharmaceutical utilization data, as applicable;
2. total claims paid and claims paid by year, practice type, and service category, for in-network and out-of-network providers;
3. premiums the employer paid by month; and
4. the number of people insured under the policy by month and coverage tier, including single, two-person, and family.

The bill requires the insurer or entity to disclose only information that (1) cannot be used to identify an individual and (2) is disclosable under the federal Health Insurance Portability and Accountability Act (HIPAA) or its regulations.

Utilization Data

The bill defines "utilization data" as the aggregate number of (1) procedures performed for the employer's covered employees, by practice type and service category, and (2) prescriptions filled for those employees, by prescription drug name.

Claims Paid

The bill defines "claims paid" as the amounts paid for the employer's covered employees' medical services and supplies and prescriptions. It excludes expenses for stop-loss coverage, reinsurance, enrollee educational programs, other cost containment programs or

features, administrative costs, and profit.

REQUIRED FORMAT

The insurer or other entity must provide the information (1) in a written report, (2) electronically in a secure e-mail or through a file transfer protocol site, or (3) through a secure website or website portal the employer can access.

BACKGROUND

Federal Privacy Requirements

HIPAA limits an insurer's release of protected health information (PHI). PHI includes medical information that contains information that could identify a person, including name, Social Security number, telephone number, medical record number, and ZIP code. Federal regulations protect this information regardless of how it is stored or transmitted.

The penalty under HIPAA for wrongful disclosure of individually identifiable health information is a \$50,000 fine, imprisonment for up to one year, or both. Wrongful disclosure under false pretenses is punishable by a \$100,000 fine, imprisonment for up to five years, or both. Committing wrongful disclosure with intent to sell the information is punishable by a \$250,000 fine, imprisonment for up to 10 years, or both.

State Insurance Information and Privacy Protection Act

State law prohibits an insurer, agent, or support organization from disclosing any personal or privileged information about a person that was collected or received in connection with an insurance transaction, but specifies numerous instances when disclosure is permissible. For example, disclosure of personal information is permissible if it is (1) made to a group policyholder for the purpose of (a) reporting claims experience or (b) conducting an audit of the insurer's or agent's operations or services, provided the information disclosed is reasonably necessary for the policyholder to conduct the audit. Disclosure is also permissible if otherwise permitted or required by

law (CGS § 38a-988). An insurer or agent must provide all insurance applicants and policyholders a written notice of its information practices, including the types of personal information that may be disclosed and circumstances under which disclosure is made. The notice must describe only those circumstances that occur with such frequency as to indicate a general business practice (CGS § 38a-979).

The law defines “personal information” as any individually identifiable information, including a person’s name, address, and medical record information, collected in connection with an insurance transaction from which judgments can be made about the person’s character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. “Privileged information” is individually identifiable information relating to an insurance claim or a civil or criminal proceeding involving the person.

“Medical record information” is information (1) related to a person’s physical, mental, or behavioral health condition or medical history or treatment and (2) a medical professional or institution obtained from a pharmacy or pharmacist; the person or person’s spouse, parent, or legal guardian; or providing or paying for health care. The law excludes from the definition such information if personal identifiers that either directly reveal the patient’s identity, or provide a means of identifying the patient, have been removed or have been encrypted or encoded so that the patient’s identity is not revealed without having to use an encryption key or code.

The law subjects a person who violates it (1) negligently to a fine of up to \$2,000 for each violation, not to exceed \$20,000, and (2) intentionally to a fine of up to \$5,000 for each violation, not to exceed \$50,000 (CGS § 38a-993).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 14 Nay 3 (02/23/2010)