



House of Representatives

General Assembly

File No. 437

February Session, 2012

Substitute House Bill No. 5038

House of Representatives, April 16, 2012

The Committee on Public Health reported through REP. RITTER, E. of the 38th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

***AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS CONCERNING AN ALL-PAYER CLAIMS
DATABASE PROGRAM.***

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

1 Section 1. Section 19a-724 of the 2012 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective October 1, 2012*):

4 (a) (1) As used in this section and section 19a-725, "Affordable Care
5 Act" means the Patient Protection and Affordable Care Act, P.L. 111-
6 148, as amended by the Health Care and Education Reconciliation Act,
7 P.L. 111-152, as both may be amended from time to time, and federal
8 regulations adopted thereunder.

9 (2) As used in this section and section 19a-724a, as amended by this
10 act: (A) "All-payer claims database" means a database that receives and
11 stores data from a reporting entity relating to medical insurance
12 claims, dental insurance claims, pharmacy claims and information

13 from enrollment and eligibility files; and (B) "reporting entity" means
14 (i) an insurer, as described in section 38a-1, licensed to do health
15 insurance business in this state, (ii) a health care center, as defined in
16 section 38a-175, (iii) an insurer or health care center that provides
17 coverage under Part C or Part D of Title XVIII of the Social Security
18 Act, as amended from time to time, to residents of this state, (iv) a
19 third-party administrator, as defined in section 38a-720, (v) a
20 pharmacy benefits manager, as defined in section 38a-479aaa, (vi) a
21 hospital service corporation, as defined in section 38a-199, (vii) a
22 nonprofit medical service corporation, as defined in section 38a-214,
23 (viii) a fraternal benefit society, as described in section 38a-595, that
24 transacts health insurance business in this state, (ix) a dental plan
25 organization, as defined in section 38a-577, (x) a preferred provider
26 network, as defined in section 38a-479aa, or (xi) any other person, as
27 defined in section 38a-1, that administers health care claims and
28 payments pursuant to a contract or agreement or is required by statute
29 to administer such claims and payments.

30 (b) There is established, in the office of the Lieutenant Governor, the
31 Office of Health Reform and Innovation. The Special Advisor to the
32 Governor on Healthcare Reform shall direct the activities of the Office
33 of Health Reform and Innovation.

34 (c) The Office of Health Reform and Innovation shall:

35 (1) Coordinate and implement the state's responsibilities under state
36 and federal health care reform;

37 (2) Identify (A) federal grants and other nonstate funding sources to
38 assist with implementing the Affordable Care Act, and (B) other
39 measures which further enhance access to health care, reduce costs and
40 improve the quality of health care in the state;

41 (3) Recommend and advance executive action and legislation to
42 effectively and efficiently implement the Affordable Care Act, and
43 state health care reform initiatives;

44 (4) Design processes to maximize stakeholder and public input and
45 ensure transparency in implementing health care reform;

46 (5) Ensure ongoing information sharing and coordination of efforts
47 with the General Assembly and state agencies concerning public health
48 and health care reform;

49 (6) Report on or after January 1, 2012, and annually thereafter, in
50 accordance with section 11-4a, to the joint standing committees of the
51 General Assembly having cognizance of matters relating to
52 appropriations and the budgets of state agencies, human services,
53 insurance and public health on the progress of state agencies
54 concerning implementation of the Affordable Care Act;

55 (7) Ensure coordination of efforts with state agencies concerning
56 prevention and management of chronic illnesses;

57 (8) Ensure that the structures of state government are working in
58 concert to effectively implement federal and state health care reform;

59 (9) Ensure, in consultation with the Connecticut Health Insurance
60 Exchange and the Department of Social Services, the necessary
61 coordination between said exchange and Medicaid enrollment
62 planning; [and]

63 (10) Maximize private philanthropic support to advance health care
64 reform initiatives;

65 (11) Oversee the planning, implementation and administration of an
66 all-payer claims database program for the purpose of collecting,
67 assessing and reporting health care information relating to safety,
68 quality, cost-effectiveness, access and efficiency for all levels of health
69 care;

70 (12) Ensure that data from reporting entities is securely collected,
71 compiled and stored in accordance with state and federal law; and

72 (13) Ensure that data from reporting entities is accurate and valid.

73 (d) The Office of Health Reform and Innovation, in consultation
74 with the SustiNet Health Care Cabinet established pursuant to section
75 19a-725, shall [, on or before August 1, 2011,] convene a consumer
76 advisory board that consists of not less than seven members.

77 (e) The Office of Health Reform and Innovation and the Office of the
78 Healthcare Advocate shall provide staff support to the SustiNet Health
79 Care Cabinet.

80 (f) The Office of Health Reform and Innovation shall maintain a
81 central comprehensive health reform web site.

82 (g) State agencies shall, within available appropriations, use their
83 best efforts to provide assistance to the Office of Health Reform and
84 Innovation.

85 (h) The Office of Health Reform and Innovation, in consultation
86 with the SustiNet Health Care Cabinet, may retain any consultants
87 necessary to carry out the statutory responsibilities of said office,
88 except the Office of Health Reform and Innovation may, without
89 consulting with said cabinet, retain any consultants necessary to assist
90 with the planning or implementation of the all-payer claims database
91 program. Consultants may be retained by said office for purposes that
92 include, but are not limited to, conducting feasibility and risk
93 assessments required to implement, as may be practicable, private and
94 public mechanisms to provide adequate health insurance products to
95 individuals, small employers, nonstate public employers, municipal-
96 related employers and nonprofit employers, commencing on January
97 1, 2014. Not later than October 1, 2012, the Office of Health Reform and
98 Innovation and the SustiNet Health Care Cabinet shall make
99 recommendations to the Governor based on the results of the analyses
100 undertaken pursuant to this subsection.

101 (i) The Special Advisor to the Governor on Healthcare Reform may
102 (1) in consultation with the All-Payer Claims Database Advisory
103 Group, described in section 19a-724a, as amended by this act, enter
104 into a contract with a person or entity to implement or administer the

105 all-payer claims database program; (2) enter into a contract or take any
106 action that is necessary to obtain fee-for-service health claims data
107 under the state medical assistance program or Medicare Part A or Part
108 B; or (3) enter into a contract for the collection, management or analysis
109 of data received from reporting entities. Any such contract for the
110 collection, management or analysis of such data shall expressly
111 prohibit the disclosure of such data for purposes other than the
112 collection, management or analysis of such data pursuant to the terms
113 of the contract.

114 (j) The Special Advisor to the Governor on Healthcare Reform shall:
115 (1) Utilize data in the all-payer claims database to provide health care
116 consumers in the state with information concerning the cost and
117 quality of health care services that will allow such consumers to make
118 economically sound and medically appropriate health care decisions;
119 and (2) make data in the all-payer claims database available to any
120 state agency, insurer, employer, health care provider, consumer of
121 health care services, researcher or the Connecticut Health Insurance
122 Exchange for the purpose of allowing such person or entity to review
123 such data as it relates to health care utilization, costs or quality of
124 health care services. Such disclosure shall be made in a manner to
125 protect the confidentiality of health information, as defined in 45 CFR
126 160.103, and other information, as required by state and federal law.

127 (k) The Special Advisor to the Governor on Healthcare Reform may
128 set a fee to be charged to each person to access data stored in the all-
129 payer claims database.

130 (l) The Office of Health Reform and Innovation may accept grants
131 from the federal government or any other source for the purpose of
132 planning, implementing or administering the all-payer claims database
133 program.

134 (m) The Special Advisor to the Governor on Healthcare Reform may
135 adopt regulations, in accordance with the provisions of chapter 54, to
136 implement the provisions of this section concerning the all-payer
137 claims database program.

138 (n) Any reporting entity that fails to report in accordance with the
139 provisions of this section or regulations adopted pursuant to this
140 section may be assessed a civil penalty in an amount not to exceed one
141 thousand dollars per day. A civil penalty assessed under this section is
142 not allowable as a cost for the purpose of rate determination or
143 reimbursement by a third-party payer.

144 Sec. 2. Section 19a-724a of the 2012 supplement to the general
145 statutes is repealed and the following is substituted in lieu thereof
146 (*Effective October 1, 2012*):

147 (a) The Office of Health Reform and Innovation established under
148 subsection (b) of section 19a-724, as amended by this act, shall convene
149 a working group to be known as the All-Payer Claims Database
150 Advisory Group. Said group shall develop a plan to implement a state-
151 wide multipayer data initiative to enhance the state's use of health care
152 data from multiple sources to increase efficiency, enhance outcomes
153 and improve the understanding of health care expenditures in the
154 public and private sectors. [Such] Said group shall include, but not be
155 limited to, the Secretary of the Office of Policy and Management, the
156 Comptroller, the Commissioners of Public Health, [and] Social
157 Services, and Mental Health and Addiction Services, the Insurance
158 Commissioner, the Health Care Advocate, the Chief Information
159 Officer, representatives of health insurance companies, health
160 insurance purchasers, hospitals, consumer advocates and health care
161 providers. The Special Advisor to the Governor on Healthcare Reform
162 may appoint additional members to said group.

163 (b) The Office of Health Reform and Innovation shall submit, in
164 accordance with section 11-4a, a report on such plan to the joint
165 standing committees of the General Assembly having cognizance of
166 matters relating to appropriations, insurance and public health.

167 Sec. 3. (*Effective from passage*) On or before October 1, 2012, the All-
168 Payer Claims Database Advisory Group, established pursuant to
169 section 19a-724a of the general statutes, as amended by this act, shall
170 report to the Governor and the joint standing committee of the General

171 Assembly having cognizance of matters relating to public health
 172 concerning the all-payer claims database program described in section
 173 19a-724 of the general statutes, as amended by this act. Such report
 174 shall include, but not be limited to: (1) Recommendations concerning
 175 the person or entity to implement and administer the all-payer claims
 176 database program; (2) a recommended timeline to transfer authority
 177 for the implementation or administration of such program to such
 178 person or entity; and (3) recommendations concerning the
 179 administration of such program.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2012</i>	19a-724
Sec. 2	<i>October 1, 2012</i>	19a-724a
Sec. 3	<i>from passage</i>	New section

Statement of Legislative Commissioners:

In section 1(a)(2)(i) "defined" was changed to "described", for accuracy; in section 1(a)(2)(vii) "a medical service corporation" was changed to "a nonprofit medical service corporation", for accuracy; in section 1(i)(3), "received from reporting entities" was inserted after "data", for clarity; and, in the last sentence of section 1(i), "such" was inserted before the first "data", for clarity.

PH *Joint Favorable Subst.*

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:

Agency Affected	Fund-Effect	FY 13 \$	FY 14 \$
Lt. Governor's Off.	GF - Cost	\$1 Million to \$2 Million	\$1 Million to \$2 Million

Note: GF=General Fund

Municipal Impact: None

Explanation

There is a significant cost, estimated to be between \$1 million and \$2 million annually, to the Office of Healthcare Reform and Innovation (OHRI), within the Lt. Governor's Office, associated with creating and maintaining an all-payer claims database.

These costs cover initial database development, as well as ongoing system maintenance, data collection, analysis and report creation. Based on experiences in other states, it is estimated that costs will range from \$1 million to \$2 million per year.

To the extent that OHRI may obtain federal or private funds for the all-payer claims database, this would offset the cost to the state.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Lt. Governor's Office, All-Payer Claims Database Council

OLR Bill Analysis**sHB 5038*****AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING AN ALL-PAYER CLAIMS DATABASE PROGRAM.*****SUMMARY:**

This bill requires the Office of Health Reform and Innovation (OHRI) to establish an all-payer claims database program for receiving and storing data relating to medical and dental insurance claims, pharmacy claims, and information from enrollment and eligibility files from reporting entities. The bill requires insurers or anyone else that administers health care claims and payments (“all payers”) to provide information for inclusion in the database. It establishes civil penalties of up to \$1,000 per day for entities that fail to report as required by the bill and implementing regulations.

The bill specifies how OHRI must use the data in the database and makes information in the database broadly available for information relating to health care use, cost, quality, and services. Data disclosure must protect the confidentiality of individual health information.

The bill allows OHRI to independently hire consultants to help it plan or implement the program. It also allows the special advisor to the governor on healthcare reform (who directs OHRI’s activities) to contract with an outside entity to implement or administer the program, but she can only do so in consultation with an existing working group that is required by law to develop a plan for a state-wide multipayer data initiative. The bill names the working group the All-Payer Claims Database Advisory Group, expands its membership, and requires it to report on the database program.

The bill also makes technical changes.

EFFECTIVE DATE: October 1, 2012, except the advisory group reporting requirement is effective upon passage.

ALL-PAYER CLAIMS DATABASE PROGRAM

Program Implementation, Administration, and Purpose

PA 11-58 established OHRI within the Office of the Lieutenant Governor. OHRI is currently charged with coordinating and implementing the state's responsibilities under state and federal health care reform, among other things, and is under the direction of the special advisor to the governor on healthcare reform.

The bill requires OHRI to oversee the planning, implementation, and administration of an all-payer claims database program for receiving and storing data on medical and dental insurance claims, pharmacy claims, and information from reporting entities' enrollment and eligibility files.

In addition to other contracting authority explained below, the bill creates two different processes for OHRI to enter into private contracts depending upon whether the contract involves planning. It allows the special advisor, in consultation with the All-Payer Claims Database Advisory Group (see below), to contract with another person or entity to implement or administer the program. It also allows OHRI to hire consultants needed to help plan or implement the program, without consulting the advisory group or anyone else.

Under the bill, OHRI's authority to hire consultants to help plan or implement the database program without consulting anyone is an exception to the requirement in current law that OHRI consult with the Sustinet Health Care Cabinet before hiring consultants needed to carry out its duties.

The purpose of the program is the collection, assessment, and reporting of health care information relating to safety, quality, cost-effectiveness, access, and efficiency for all levels of health care. Under the bill, OHRI must ensure that data from reporting entities is (1) securely collected, compiled, and stored according to state and federal

law and (2) accurate and valid.

The bill allows the special advisor to adopt implementing regulations.

Reporting Entities

Under the bill, the following entities are required to provide data to the all-payer claims database:

1. insurers licensed to conduct health insurance business in Connecticut,
2. health care centers (i.e., HMOs),
3. insurers or health care centers that provide state residents with coverage under Medicare parts C or D,
4. third-party administrators,
5. pharmacy benefits managers,
6. hospital service corporations,
7. nonprofit medical service corporations,
8. fraternal benefit societies that transact health insurance business in Connecticut,
9. dental plan organizations,
10. preferred provider networks, and
11. any other individual or legal entity that administers health care claims and payments under a contract or agreement or is required by law to administer such claims and payments.

Civil Penalties

The bill subjects reporting entities to civil penalties of up to \$1,000 per day for failing to report as required by the bill or implementing regulations. The bill prohibits reporting entities from passing

monetary fines on to rate-setting entities or third-party payers.

While the bill establishes a per day penalty for failure to report, it does not specify when reporting entities must report their data or how often they must do so.

Use and Availability of Data

The bill requires the special advisor to use the database to provide the state's health care consumers with information about the cost and quality of health care services so that they may make economically sound and medically appropriate health care decisions. She also must make data in the database available to any state agency, insurer, employer, health care provider, health care consumer, researcher, or the Connecticut Health Insurance Exchange (a quasi-public agency created to satisfy requirements of the federal Patient Protection and Affordable Care Act, see BACKGROUND) to allow these people or entities to review the data relating to health care utilization, cost, or service quality.

Any such disclosure must protect the confidentiality of health information as defined in federal Health and Human Services (HHS) regulations (see BACKGROUND) and other information as required by state and federal law.

Fees for Accessing Data

The bill allows the special advisor to charge a fee to those seeking access to the data in the database.

Grants

Under the bill, OHRI can accept grants from any source to plan, implement, or administer the database program.

Other Contracting Authority

The bill allows the special advisor to contract for or take other necessary actions to obtain fee-for-service data under the state medical assistance program or Medicare parts A and B. She may also contract

for collection, management, or analysis of data received from reporting entities, but any such contract must expressly prohibit the disclosure of the data for any purpose other than its collection, management, or analysis under the contract.

ADVISORY GROUP

Current law requires OHRI to convene a working group to develop a plan implementing a state-wide multipayer data initiative to improve the state's use of health care data from multiple sources to increase efficiency, enhance outcomes, and improve the understanding of health care spending in the public and private sectors.

The bill renames the working group the All-Payer Claims Database Advisory Group. It adds to the group's membership the Department of Mental Health and Addiction Services commissioner, the health care advocate, and the state chief information officer. The bill also allows the special advisor to appoint additional members. By law, the group also includes the Office of Policy and Management secretary; the comptroller; the commissioners of public health, social services, and insurance; representatives of health insurance companies; health insurance purchasers; hospitals; consumer advocates; and health care providers.

The bill requires the advisory group, by October 1, 2012, to report on the database program to the governor and the Public Health Committee. The report must include recommendations on (1) the person or entity to implement and administer the database program, (2) a timeline to transfer authority for implementing or administering the program to such person or entity, and (3) program administration.

BACKGROUND

Related Federal Law

Affordable Care Act. Among numerous other provisions, the federal Patient Protection and Affordable Care Act requires most people to purchase health insurance; makes qualified health plans available through insurance exchanges, which the states must create;

and imposes new requirements on group and individual insurance plans.

HIPAA. The Health Insurance Portability and Accountability Act’s (HIPAA) “privacy rule” sets national standards to protect the privacy of health information. “Covered entities” such as health care providers, health plans (e.g., health insurers, HMOs, Medicare, and Medicaid), and health care clearinghouses must follow HIPAA rules. The HIPAA privacy rule protects individually identifiable health information by defining and limiting the circumstances under which covered entities may use or disclose such information.

Definition of Health Information. Under HHS regulations, “health information” means any information, whether oral or recorded in any form or medium, that:

1. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual (45 C.F.R. § 160.103).

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 27 Nay 1 (03/29/2012)