General Assembly

Raised Bill No. 913

January Session, 2015

LCO No. **3471**

Referred to Committee on LABOR AND PUBLIC EMPLOYEES

Introduced by:
(LAB)

AN ACT CONCERNING HEALTH CARE DATA REPORTING.

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

Section 1. (NEW) (*Effective July 1, 2015*) (a) Not later than October 1, 2016, and annually thereafter, each municipality that sponsors a group health policy or plan for its active employees, early retirees and retirees that provides coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes shall submit electronically to the State Comptroller, in a form prescribed by the Comptroller, the following information for the policy or plan year immediately preceding:

(1) A list of each type of group health policy or plan offered to the municipality's employees, early retirees and retirees and specific details for each such policy or plan, including, but not limited to:

(A) Covered benefits and any limits on such benefits;

(B) (i) The total premium costs or, if applicable, premium equivalent costs for each policy or plan, organized by coverage tier, including, but

not limited to, single, two-person and family including dependents for active employees, early retirees and retirees, and (ii) the employee share, the early retiree share and the retiree share of each such total premium cost;

(C) Employee, early retiree and retiree cost-sharing requirements such as coinsurance, copayments, deductibles and other out-of-pocket expenses associated with in-network and out-of-network providers; and

(D) If a municipality sponsors a prescription drug plan, the value of any rebates or cost reductions provided to such municipality for such plan;

(2) A list of the total number of employees, early retirees and retirees in each policy or plan, organized by (A) municipal department, (B) collective bargaining unit, if applicable, (C) coverage tier, including, but not limited to, single, two-person and family, including dependents, and (D) active employee, early retiree or retiree status; and

(3) For the two policy or plan years immediately preceding, the percentage increase or decrease in the policy or plan costs, calculated as the total premium costs, inclusive of any premiums or contributions paid by active employees, early retirees and retirees, divided by the total number of active employees, early retirees and retirees covered by such policy or plan.

(b) No municipality submitting information pursuant to subsection (a) of this section shall include health information in such information.

Sec. 2. Section 38a-513f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) As used in this section:

(1) "Claims paid" means the amounts paid for the covered

employees of an employer by an insurer, health care center, hospital service corporation, medical service corporation or other entity as specified in subdivision (1) of subsection (b) of this section for medical services and supplies and for prescriptions filled, but does not include expenses for stop-loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features, administrative costs or profit.

(2) "Employer" means any town, city, borough, school district, taxing district or fire district employing more than fifty employees.

(3) "Utilization data" means (A) the aggregate number of procedures or services performed for the covered employees of the employer, by practice type and by service category, or (B) the aggregate number of prescriptions filled for the covered employees of the employer, by prescription drug name.

(b) (1) Each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall:

[(1)**]** (A) Not later than October first, annually, provide to an employer sponsoring such policy, free of charge, the following information for the most recent thirty-six-month period or for the entire period of coverage, whichever is shorter, ending not more than sixty days prior to the date of the provision of such information, in a format as set forth in **[**subdivision (3)**]** subparagraph (C) of this **[**subsection**]** subdivision:

[(A)**]** (i) Complete and accurate medical, dental and pharmaceutical utilization data, as applicable;

[(B)**]** (ii) Claims paid by year, aggregated by practice type and by service category, each reported separately for in-network and out-of-

network providers, and the total number of claims paid;

[(C)**]** (iii) Premiums paid by such employer by month; and

[(D)**]** (iv) The number of insureds by coverage tier, including, but not limited to, single, two-person and family including dependents, by month;

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

[(3)**]** (C) Provide such information **[**(A)**]** (i) in a written report, **[**(B)**]** (ii) through an electronic file transmitted by secure electronic mail or a file transfer protocol site, or **[**(C)**]** (iii) through a secure web site or web site portal that is accessible by such employer.

[(c)**]** (2) Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall not be required to provide such information to the employer more than once in any twelve-month period.

[(d) (1)**]** (3) (A) Except as provided in **[**subdivision (2)**]** subparagraph (B) of this **[**subsection**]** subdivision, information provided to an employer pursuant to **[**subsection (b) of this section**]** subdivision (1) of this subsection shall be used by such employer only for the purposes of obtaining competitive quotes for group health insurance or to promote wellness initiatives for the employees of such employer.

[(2)**]** (B) Any employer may provide to the Comptroller upon request the information disclosed to such employer pursuant to

[subsection (b) of this section**]** subdivision 1 of this subsection. The Comptroller shall maintain as confidential any such information.

[(e)**]** (4) Any information provided to an employer in accordance with **[**subsection (b) of this section**]** subdivision (1) of this subsection or to the Comptroller in accordance with **[**subdivision (2)**]** subparagraph (B) of **[**subsection (d)**]** subdivision (3) of this **[**section**]** subsection shall not be subject to disclosure under section 1-210. An employee organization, as defined in section 7-467, that is the exclusive bargaining representative of the employees of such employer shall be entitled to receive claim information from such employer in order to fulfill its duties to bargain collectively pursuant to section 7-469.

[(f)**]** (c) If a subpoena or other similar demand related to information provided pursuant to subsection (b) of this section is issued in connection with a judicial proceeding to an employer that receives such information, such employer shall immediately notify the insurer, health care center, hospital service corporation, medical service corporation or other entity that provided such information to such employer of such subpoena or demand. Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall have standing to file an application or motion with the court of competent jurisdiction to quash or modify such subpoena. Upon the filing of such application or motion by such insurer, health care center, hospital service corporation, medical service corporation or other entity, the subpoena or similar demand shall be stayed without penalty to the parties, pending a hearing on such application or motion and until the court enters an order sustaining, quashing or modifying such subpoena or demand.

(d) (1) Not later than October 1, 2015, and annually thereafter, each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy sponsored by an employer and providing either

administrative services only or providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall submit to the Comptroller the information set forth in subparagraphs (A)(i) and (A)(ii) of subdivision (1) of subsection (b) of this section for the policy year immediately preceding for each such employer.

(2) Such information shall be submitted electronically to the Comptroller, in a form prescribed by the Comptroller, regardless of whether an employer requests such information pursuant to subparagraph (A) of subdivision (1) of subsection (b) of this section. Disclosure of any such information to the Comptroller pursuant to this subsection shall be made in compliance with subparagraph (B) of subdivision (1) of subsection (b) of this section.

Sec. 3. (*Effective July 1, 2015*) (a) With respect to the group hospitalization and medical and surgical insurance plans established under subsection (a) of section 5-259 of the general statutes, on and after July 1, 2015, and until June 30, 2016:

(1) The office of the State Comptroller shall have the authority to convene a working group, including, but not limited to, (A) to the extent applicable, health insurance companies, health care centers, hospital service corporations, medical service corporations or other entities delivering, issuing for delivery, renewing, amending or continuing such plans, (B) third-party administrators providing administrative services only for such plans pursuant to subdivision (2) of subsection (m) of section 5-259 of the general statutes, (C) health care providers, (D) health care facilities, (E) the Office of Policy and Management, and (F) state employees and retirees, to facilitate the development and establishment of health care provider payment reforms for the group hospitalization and medical and surgical insurance plans established under subsection (a) of section 5-259 of the general statutes, including, but not limited to, multipayer initiatives, patient-centered medical homes, primary care case management,

value-based purchasing and bundled purchasing. Any participation by such entities and individuals shall be on a voluntary basis.

(2) (A) The Comptroller, or the Comptroller's designee, may (i) conduct a survey of the entities and individuals specified in subparagraphs (A) to (D), inclusive, of subdivision (1) of this subsection, concerning payment delivery reforms, and (ii) convene meetings of the working group at a time and place that is convenient for the entities and individuals specified in subparagraphs (A) to (F), inclusive, of subdivision (i) of this subsection.

(B) The Comptroller, or the Comptroller's designee, shall ensure that no such survey or working group participants shall solicit, share or discuss pricing information.

(C) (i) Any survey conducted pursuant to subparagraph (A) of this subdivision shall not be a violation of chapter 624 of the general statutes or subject to disclosure under section 1-210 of the general statutes.

(ii) Any meeting convened pursuant to subparagraph (A) of this subdivision shall not be a violation of chapter 624 of the general statutes or constitute a meeting for the purposes of chapter 14 of the general statutes.

(3) (A) If the Comptroller determines that entering a cooperative agreement with any of the entities or individuals specified in subparagraphs (A) to (D), inclusive, of subdivision (1) of this subsection will likely produce efficiencies and improvements in health care outcomes, the Comptroller may enter into one or more such agreements to (i) identify and reward high quality, low-cost health care providers, (ii) create enrollee incentives to receive care from such providers, and (iii) create enrollee incentives to promote personal health behaviors that will prevent or effectively manage chronic diseases, including, but not limited to, tobacco cessation, weight control and physical activity.

(B) The Comptroller may establish guidelines for such cooperative agreements. Any such agreement shall be consistent with federal antitrust laws and regulations promulgated by the Federal Trade Commission and chapter 624 of the general statutes.

(b) Not later than January 1, 2017, the Comptroller shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, labor and public health on the recommendations of any working group convened by the Comptroller pursuant to subsection (a) of this section. Such report shall include, but not be limited to, (1)(A) any cost containment measures, and (B) descriptions of any quality measurement or quality improvement initiatives implemented as a result of the recommendations of such working group, and (2) any cost savings or health outcome improvements associated with such measures or initiatives.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2015*	New section
Sec. 2	*July 1, 2015*	38a-513f
Sec. 3	*July 1, 2015*	New section

Statement of Purpose:

To require each municipality that sponsors a group health policy or plan to submit information regarding such policy or plan to the State Comptroller for analysis and to allow the Comptroller to enter into cooperative health care agreements that may allow individuals to acquire low-cost, high-quality health care.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]