Substitute Senate Bill No. 246

Public Act No. 18-77

AN ACT LIMITING AUTO REFILLS OF PRESCRIPTION DRUGS COVERED UNDER THE MEDICAID PROGRAM AND REQUIRING THE COMMISSIONER OF SOCIAL SERVICES TO PROVIDE CHIP DATA TO THE HEALTH INFORMATION TECHNOLOGY OFFICER.

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

Section 1. (NEW) (*Effective from passage*) (a) The Commissioner of Social Services, in accordance with subsections (b) to (d), inclusive, of this section, may prohibit a pharmacy provider from automatically refilling certain prescription drugs for a medical assistance recipient, regardless of whether a recipient requests or consents to participation in an automatic prescription drug refill program. For any prescription subject to this prohibition, the Department of Social Services shall not make payment for a refill without an explicit verbal or written request for such payment from the recipient or the recipient's legal representative.

(b) The commissioner shall submit recommendations on the types, classes or usage of prescription drugs to be subject to the automatic refill prohibition described in subsection (a) of this section, and for prescription drugs to be exempted from such prohibition, to the joint standing committee of the General Assembly having cognizance of matters relating to human services.

(c) Not later than thirty days after the date of their receipt of such recommendations, the joint standing committee shall hold a public hearing on the recommendations, and notify the Commissioner of Social Services of the date and time of the public hearing. If the joint standing committee does not schedule the public hearing, the recommendations shall be deemed approved. At the conclusion of the public hearing held in accordance with the provisions of this section, the joint standing committee shall advise the commissioner of its approval, denial or modifications, if any, of the commissioner's recommendations. If the joint standing committee denies the commissioner's recommendations, the commissioner shall not implement such recommendations but may submit new recommendations to the committee for action in accordance with this subsection.

(d) The commissioner shall submit the recommendations, as approved or modified in accordance with subsection (c) of this section, to the Pharmaceutical and Therapeutics Committee established pursuant to section 17b-274d of the general statutes, as amended by this act.

Sec. 2. Subsection (j) of section 17b-274d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(j) The Pharmaceutical and Therapeutics Committee may also make recommendations to the department regarding <u>(1)</u> the prior authorization of any prescribed drug<u>, and (2) what prescribed drug, if any, should be eligible for automatic refill</u>.

Sec. 3. Section 19a-755a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "All-payer claims database" means a database that receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files.

(2) (A) "Reporting entity" means:

(i) An insurer, as described in section 38a-1, licensed to do health insurance business in this state;

(ii) A health care center, as defined in section 38a-175;

(iii) An insurer or health care center that provides coverage under Part C or Part D of Title XVIII of the Social Security Act, as amended from time to time, to residents of this state;

(iv) A third-party administrator, as defined in section 38a-720;

(v) A pharmacy benefits manager, as defined in section 38a-479aaa;

(vi) A hospital service corporation, as defined in section 38a-199;

(vii) A nonprofit medical service corporation, as defined in section 38a-214;

(viii) A fraternal benefit society, as described in section 38a-595, that transacts health insurance business in this state;

(ix) A dental plan organization, as defined in section 38a-577;

(x) A preferred provider network, as defined in section 38a-479aa; and

(xi) 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.

(B) "Reporting entity" does not include an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

(3) "Medicaid data" means the Medicaid provider registry, health claims data and Medicaid recipient data maintained by the Department of Social Services.

(4) "CHIP data" means the provider registry, health claims data and recipient data maintained by the Department of Social Services to administer the Children's Health Insurance Program.

(b) (1) There is established an all-payer claims database program. The Health Information Technology Officer, designated under section 19a-755, shall: (A) Oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care; (B) ensure that data received is securely collected, compiled and stored in accordance with state and federal law; and (C) conduct audits of data submitted by reporting entities in order to verify its accuracy.

(2) The Health Information Technology Officer shall seek funding from the federal government, other public sources and other private sources to cover costs associated with the planning, implementation and administration of the all-payer claims database program.

(3) (A) Upon the adoption of reporting requirements as set forth in subsection (b) of section 19a-755, a reporting entity shall report health care information for inclusion in the all-payer claims database in a

form and manner prescribed by the Health Information Technology Officer. The Health Information Technology Officer may, after notice and hearing, impose a civil penalty on any reporting entity that fails to report health care information as prescribed. Such civil penalty shall not exceed one thousand dollars per day for each day of violation and shall not be imposed as a cost for the purpose of rate determination or reimbursement by a third-party payer.

(B) The Health Information Technology Officer may provide the name of any reporting entity on which such penalty has been imposed to the Insurance Commissioner. After consultation with said officer, the commissioner may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to recover any penalty imposed pursuant to subparagraph (A) of this subdivision.

(4) The Commissioner of Social Services shall submit Medicaid and CHIP data to the Health Information Technology Officer for inclusion in the all-payer claims database only for purposes related to administration of the State Medicaid **[**Plan**]** and CHIP Plans, in accordance with 42 CFR 431.301 to 42 CFR 431.306, inclusive.

(5) The Health Information Technology Officer shall: (A) Utilize data in the all-payer claims database to provide health care consumers in the state with information concerning the cost and quality of health care services for the purpose of allowing such consumers to make economically sound and medically appropriate health care decisions; and (B) make data in the all-payer claims database 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, as defined in 45 CFR 160.103, as amended from time to time, 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, any disclosure thereof made pursuant to this subdivision shall have identifiers removed, as set forth in 45 CFR 164.514, as amended from time to time. Any disclosure made pursuant to this subdivision of information other than health information shall be made in a manner to protect the confidentiality of such other information as required by state and federal law. The Health Information Technology Officer may set a fee to be charged to each person or entity requesting access to data stored in the all-payer claims database.

(6) The Health Information Technology Officer may (A) in consultation with the All-Payer Claims Database Advisory Group set forth in section 17b-59f, enter into a contract with a person or entity to plan, implement or administer the all-payer claims database program, (B) enter into a contract or take any action that is necessary to obtain data that is the same data required to be submitted by reporting entities under Medicare Part A or Part B, (C) enter into a contract for the collection, management or analysis of data received from reporting entities, and (D) in accordance with subdivision (4) of this subsection, enter into a contract or take any action that is necessary to obtain Medicaid and CHIP data. Any such contract for the collection, management or analysis of such data shall expressly prohibit the disclosure of such data for purposes other than the purposes described in this subsection.

Approved June 1, 2018