OLR Bill Analysis

sSB 242

AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY'S RECOMMENDATIONS REGARDING THE ALL-PAYER CLAIMS DATABASE.

SUMMARY

By law, the state's All-Payer Claims Database (APCD) receives and stores data from reporting entities (e.g., hospitals, pharmacy benefits managers, or health insures) related to medical and dental insurance, pharmacy, and other insurance claims information. Starting June 30, 2026, this bill requires the APCD to include nonclaims data from the prior calendar year. This includes alternative payment models, such as care management, shared savings, quality payments and bonuses, pharmacy rebates and other price concessions paid to insurers, information technology, and electronic medical record investments information.

It correspondingly requires the APCD Advisory Group to develop recommendations on reporting requirements for the nonclaims data and submit them to the Office of Health Strategy (OHS) by February 1, 2025. OHS must then update its APCD written procedures, based on the advisory group's recommendations, to include requirements for nonclaims data that reporting entities must submit annually, starting by June 30, 2026.

The bill also removes a provision in current law excusing hospitals from limitations in meeting their community benefit reporting requirements (see BACKGROUND) if they are not given the APCD data as required. Current law requires OHS to make APCD data available to hospitals for this purpose, to the full extent allowed by federal Health Insurance Portability and Accountability Act (HIPAA) regulations (generally, those regulations allow covered entities, under specified conditions, to use or disclose limited non-personally identifiable health

information for research, public health, or health care operations if they do so under a data user agreement (45 C.F.R. § 164.514(e)). The bill removes the requirement that OHS also do so regardless of existing state laws on using APCD data.

Lastly, the bill makes technical changes.

EFFECTIVE DATE: October 1, 2024

BACKGROUND

Community Benefit Program Reporting

By law, a community benefit program is a voluntary program to (1) promote preventive care, (2) protect health and safety, (3) improve health equity, (4) reduce health disparities, and (5) reduce the cost and economic burden of poor health for all populations within a hospital's geographic service area.

Hospitals must submit community benefit program reporting to OHS that includes three components: the hospital's community health needs assessment (CHNA), implementation strategy, and annual status report. The CHNA is due within 30 days after the hospital makes it publicly available and the implementation strategy, within 30 days after the hospital adopts it, as required by federal regulations.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 25 Nay 11 (03/22/2024)