

OLR BILL ANALYSIS

HB 5038 (LCO 519)

***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 report specified 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 rules established under it.

The bill requires OHRI to oversee the initial planning and implementation of the database program and allows the governor to transfer responsibility for implementing and administering it to a claims database administrator. The bill requires the special advisor to the governor on healthcare reform (who oversees OHRI) or the claims database administrator to prescribe program rules relating to reporting methods, data, accuracy, and disclosure. The bill specifies how they must use the data in the database and makes information in the database broadly available for information relating to health care use, cost, quality, or services.

Among other duties required by existing law, OHRI must convene a working group concerning a state-wide multipayer data initiative. This bill names the working group the All-Payer Claims Database Advisory Group and expands its duties and membership.

EFFECTIVE DATE: October 1, 2012

REPORTING ENTITIES

Under the bill, the following entities are required to provide data to

the all-payer claims database the bill creates:

1. insurers licensed to do 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 or medical service corporations,
7. fraternal benefit societies that transact health insurance business in Connecticut,
8. dental plan organizations,
9. preferred provider networks, and
10. any other individual or legal entity that administers health care claims and payments pursuant to a contract or agreement or is required by law to administer such claims and payments.

ALL-PAYER CLAIMS DATABASE

Program Implementation and Administration

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. The special advisor to the governor on healthcare reform, a cabinet-level position, must direct OHRI's activities.

The bill requires OHRI to establish and maintain an all-payer claims database program. OHRI must oversee the initial planning and implementation of the program. The bill allows the governor, in consultation with the All-Payer Claims Database Advisory Group (see below), to transfer the responsibility for implementing or administering the program to another person or entity that he designates as the claims database administrator. The administrator's responsibilities may include adopting rules, policies, and procedures for implementing or administering the program.

Program Purposes

Under the bill, OHRI must establish and maintain the all-payer claims database program to provide transparent and public reporting of health care information relating to safety, quality, cost-effectiveness, access, and efficiency for all levels of health care. OHRI must ensure that reporting entities report health care data for the following purposes:

1. determining the maximum capacity and distribution of existing health care resources;
2. identifying the health care system's demands;
3. allowing health care policymakers to make informed choices;
4. evaluating the effectiveness of intervention programs to improve health outcomes;
5. comparing the costs and effectiveness of various treatment settings and treatment approaches;
6. informing consumers about health care services;
7. improving the quality and affordability of health care and health care coverage in the state; and
8. evaluating health disparities in the state, including disparities relating to race or ethnicity.

Program Rules

Under the bill, the special advisor to the governor on healthcare reform or the claims database administrator, in consultation with the advisory group, must prescribe rules for the database program. The rules must be consistent with standards adopted by the:

1. Accredited Standards Committee X12 of the American National Standards Institute (which develops electronic data interchange standards),
2. National Council for Prescription Drug Programs,
3. All-Payer Claims Database Council,
4. Center for Medicare and Medicaid Services, and

5. Office of the National Coordinator for Health Information Technology.

These rules must establish the time, place, form, and manner for reporting entities to provide data to the program. Such rules must at least (1) require reporting entities to use unique patient and provider identifiers, (2) implement a uniform coding system that reflects health care utilization and costs for health care services, and (3) create an exemption to reporting requirements based on a minimum enrollment level.

The rules must also set reporting requirements based on data type, which at least includes (1) data relating to health care claims; (2) information in enrollment and eligibility files; and (3) reports, schedules, statistics, and other data relating to health care costs, prices, quality, utilization, or resources.

The rules must also establish protocols for (1) auditing the accuracy of reported data and (2) disclosing data contained in the database to protect the confidentiality of health information, as defined in federal Health and Human Services (HHS) regulations (see BACKGROUND) and other information as state and federal law requires.

Contracting Authority

Under the bill, the special advisor or the claims database administrator can 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. He or she may also contract for data collection, management, or analysis, 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.

Current law allows OHRI to hire consultants needed to carry out its duties, but only in consultation with the Sustinet Health Care Cabinet. The bill allows OHRI to independently hire consultants needed to help plan and implement the all-payer claims database program. It also allows the claims database administrator to retain consultants needed to implement or administer the database program.

Use and Availability of Data

The bill requires the special advisor or claims database administrator to use the database to provide the state's health care consumers with information about the cost and quality of health care

services to allow them to make economically sound and medically appropriate health care decisions. These officials 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 any such person or entity to review the data relating to health care utilization, cost, or service quality. Any such disclosure must protect the confidentiality of health care information as defined in HHS regulations and other information as required by state and federal law. The disclosure must also accord with the bill's protocols for data disclosure.

Fees for Accessing Data

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

Grants

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

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 rules. The bill prohibits reporting entities from passing monetary fines on to rate-setting entities or third-party payers.

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 expenditures in the public and private sectors. The bill renames the working group as the All-Payer Claims Database Advisory Group. It adds to the group's duties a requirement that it advise the special advisor or claims database administrator on the planning, implementation, and administration of the database program, including establishing protocols for data disclosure.

The bill adds to the advisory group's membership the Department of Mental Health and Addiction Services commissioner and the health

care advocate. The bill also allows the special advisor or claims database administrator to appoint additional members. By law, the group must also include the Office of Policy and Management secretary; comptroller; the commissioners of public health, social services, and insurance; health care providers; representatives of health insurance companies; health insurance purchasers; hospitals; and consumer advocates.

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 have to follow the 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).