

Amendment No. 1 to HB0278

Travis
Signature of Sponsor

AMEND Senate Bill No. 322

House Bill No. 278*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-2-125, is amended by deleting the section.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 2, is amended by adding the following new part:

56-2-1001.

The general assembly finds that healthcare consumers are forced to make choices within the healthcare marketplace based upon insufficient information about the costs for services and the quality of providers. Increasing transparency within the healthcare marketplace by providing consumers with accurate healthcare cost and quality data will enable healthcare consumers to increase the value they receive for their healthcare purchases by limiting out-of-pocket costs and choosing higher-quality providers. A more transparent healthcare marketplace is also more likely to experience increased quality and price competition among providers, result in less spending for unnecessary healthcare services, and encourage price competition among insurers leading to less consumer spending on premiums and deductibles. It is the intent of the general assembly to increase transparency in the healthcare marketplace through the establishment of an all payer claims database that includes a public information portal to provide healthcare consumers in this state access to accurate healthcare service cost and provider quality information.

56-2-1002.

As used in this part:

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(1) "Agency" means the health services and development agency created by § 68-11-1604;

(2) "All payer claims database" or "database" means a database composed of health insurance issuer and group health plan claims information that excludes the data elements in 45 CFR 164.514(e)(2);

(3) "Executive director" means the executive director of the health services and development agency;

(4) "Group health plan":

(A) Means an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care to employees or their dependents, as defined under the terms of the plan, or an administrator of the plan; and

(B) Does not include:

(i) A plan that is offered through a health insurance issuer;

or

(ii) A self-funded or self-insured plan that uses a health insurance issuer to administer plan benefits;

(5) "Health insurance coverage" means health insurance coverage as defined in § 56-7-2902, as well as medicare supplemental health insurance;

(6) "Health insurance issuer" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the department of commerce

and insurance, that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization, and a nonprofit hospital and medical service corporation. "Health insurance issuer" also means a pharmacy benefits manager, a third-party administrator, the state medicaid program, any managed care organization contracted with the state medicaid program to administer enrollee benefits, and an entity described in § 56-2-121; and

(7) "Lead entity" means the organization selected by the agency through the competitive bidding process and authorized by the agency to manage the operations of the all payer claims database.

56-2-1003.

(a) The executive director shall, no later than January 1, 2020, establish an all payer claims database to support transparent public reporting of healthcare information.

(b) The database must be designed to improve transparency by:

(1) Assisting healthcare consumers, providers, and facilities to make informed choices about health care;

(2) Serving as a resource to health insurance issuers, employers, healthcare consumers, research entities, state entities, and healthcare providers to allow for assessment of healthcare utilization, expenditures, and performance in this state;

(3) Enabling healthcare providers and facilities to improve performance and value in the delivery of health care to consumers by benchmarking their performance against that of others;

(4) Enabling healthcare consumers to identify value, build accurate expectations into their purchasing strategy, and reward improvement over time; and

(5) Promoting competition based on healthcare quality and cost.

(c) The database must enable the commissioner of finance and administration, the director of TennCare, the commissioner of mental health and substance abuse services, the commissioner of intellectual and developmental disabilities, the commissioner of health, and the commissioner of labor and workforce development to carry out the following duties:

(1) Improve the accessibility, adequacy, and affordability of patient health care and healthcare coverage;

(2) Identify health and healthcare needs and inform health and healthcare policy;

(3) Determine the capacity and distribution of existing healthcare resources;

(4) Evaluate the effectiveness of intervention programs on improving patient outcomes;

(5) Review costs among various treatment settings, providers, and approaches; and

(6) Provide publicly available information on healthcare providers' quality of care and cost of services.

(d) This section does not prevent a health insurance issuer from providing information on healthcare providers' quality of care in accordance with § 56-32-130(e).

(e)

(1) As required by HIPAA, the executive director or the lead entity shall not publicly disclose from the all payer claims database individually identifiable health information as defined in 45 CFR 160.103. Use of the all payer claims database is subject to restrictions required by HIPAA and other applicable privacy laws and policies. The executive director shall restrict access to the all payer claims database to agency staff or a lead entity contracted and authorized to perform the analyses contemplated by this part. The executive director shall

develop procedures and safeguards, in consultation with any advisory group created pursuant to subsection (f), to protect the security and confidentiality of data contained in the all payer claims database.

(2)

(A)

(i) The all payer claims database; summaries, source, or draft information used to construct or populate the all payer claims database; patient level claims data; reports derived from the all payer claims database; and other information submitted under this part, whether in electronic or paper form, are not a public record and are not open for inspection by members of the public under § 10-7-503. The information contained in the all payer claims database is confidential and not subject to subpoena.

(ii) The executive director may promulgate rules to authorize the public release of reports derived from the information. The executive director shall ensure that any release of reports does not result in the information losing its confidentiality or cause it to be admissible in a legal proceeding, except in administrative proceedings authorized under the rules adopted by the executive director.

(B) The executive director shall, through memoranda of understanding, allow the use of the all payer claims database by the department of finance and administration, the department of health, the department of mental health and substance abuse services, the department of intellectual and developmental disabilities, the bureau of TennCare, the department of labor and workforce development, other

departments of state government, and other entities authorized by this part for the purposes listed in subsections (b) and (c).

(C) Except for officials of this state or those officials' designees as permitted by subdivision (e)(1), this part does not permit access to or discovery of the source or draft information used to construct or populate the all payer claims database.

(f)

(1) The agency may establish an advisory group to provide recommendations on any or all of the following areas:

- (A) Submission specifications;
- (B) Patient privacy and confidentiality;
- (C) Data release;
- (D) Data aggregation; and
- (E) Security.

(2) The agency may accept, reject, or amend recommendations, in whole or in part, from the advisory group.

56-2-1004.

(a) The agency shall, no later than October 1, 2019, use a competitive solicitation procurement process, in accordance with title 12, chapter 3, to select a lead entity from among the best potential bidders to coordinate and manage the database.

(b) Due to the complexities of the all payer claims database and the unique privacy, quality, and financial objectives, the agency must award extra points in the scoring evaluation for the following elements:

(1) The bidder's degree of experience in healthcare data collection, analysis, analytics, and security, and in the development of a transparent data delivery tool;

(2) Whether the bidder has a long-term, self-sustainable financial model;

(3) The bidder's experience in convening and effectively engaging stakeholders to develop reports;

(4) The bidder's experience in meeting budget requirements and timelines for report generations; and

(5) The bidder's ability to combine cost and quality data.

(c) The lead entity may enter into a contract with a data vendor to perform data collection, processing, aggregation, extracts, and analytics. The lead entity or any contracted data vendor must:

(1) Establish a web portal that, no later than September 1, 2020, is accessible by the general public and that contains searchable information on the costs of common medical procedures and healthcare services, a system of quality ratings for healthcare providers and facilities, and a tool or interface for cost and quality comparisons among providers and facilities;

(2) Consistent with the requirements of this part, make information from the database available as a resource for public and private entities, including carriers, employers, providers, hospitals, research entities, and consumers of health care;

(3) Establish a secure data submission process with data submitters;

(4) Design data collection mechanisms with consideration for the time and cost incurred by data suppliers and others in submission and collection, and the benefits that measurement would achieve, ensuring the data submitted meet quality standards and are reviewed for quality assurance;

(5) Review submitted data files according to standards established by the agency;

(6) Assess each record for compliance with established format, frequency, and consistency criteria;

(7) Maintain responsibility for quality assurance, including, but not limited to:

- (A) The accuracy and validity of data suppliers' data;
- (B) The accuracy of dates of service spans;
- (C) Maintaining consistency of record layout and counts; and
- (D) Identifying duplicate records;

(8) Demonstrate internal controls and affiliations with separate organizations as appropriate to ensure safe data collection, actuarial support, and data review for accuracy and quality assurance;

(9) Develop protocols and policies, including prerelease peer review by data suppliers, to ensure the quality of data releases and reports;

(10) Store data on secure servers that are compliant with HIPAA and federal regulations, with access to the data strictly controlled and limited to staff with appropriate training, clearance, and background checks; and

(11) Maintain state-of-the-art security standards for transferring data to approved data requestors.

(d) The lead entity and any contracted data vendor shall submit detailed descriptions to the chief information officer of the agency to ensure robust security methods are in use. The executive director shall report the chief information officer's findings to the governor, the commerce and labor committee of the senate, and the insurance committee of the house of representatives.

(e) The lead entity is responsible for internal governance, management, and operation of the database.

56-2-1005.

(a)

(1)

(A) No later than January 1, 2020, and every month thereafter, all group health plans and health insurance issuers shall provide electronic health insurance claims data for state residents to the agency or lead entity, in accordance with standards and procedures adopted by the executive director by rule.

(B) All group health plans and health insurance issuers shall provide additional information as the executive director subsequently establishes by rule for the purpose of creating and maintaining the all payer claims database.

(C) The executive director shall strive for standards and procedures that are the least burdensome for data submitters.

(2) The collection, storage, and release of health and healthcare data and statistical information that are subject to the federal requirements of HIPAA are governed by the rules adopted in 45 CFR parts 160 and 164.

(3) All group health plans and health insurance issuers that collect the health employer data and information set (HEDIS) shall annually submit the HEDIS information to the agency in a form and in a manner prescribed by the National Committee for Quality Assurance (NCQA).

(4) If any group health plan or health insurance issuer fails to submit required data to the agency on a timely basis, the executive director may impose a civil penalty of up to five hundred dollars (\$500) for each day of delay.

(b) The executive director, in the executive director's discretion, may allow some group health plans and health insurance issuers to submit data on a quarterly basis. The executive director may also establish by rule exceptions to the reporting requirements of this part for entities based upon an entity's size, an entity's amount of claims, or other relevant factors deemed appropriate.

56-2-1006.

Beginning January 1, 2021, and no later than January 1 each year thereafter, the executive director shall report to the commerce and labor committee of the senate and the insurance committee of the house of representatives on the status of the all payer claims database, including statistics on usage of the database by consumers, observed trends in healthcare costs and quality, and any recommendations for improvements to the database.

56-2-1007.

The executive director may, subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, promulgate rules for purposes of implementing this part. The executive director is authorized to promulgate the initial rules as emergency rules pursuant to the Uniform Administrative Procedures Act prior to July 1, 2019, for the purpose of creating the all payer claims database.

56-2-1008.

If any provision of this act or its application to any person or circumstance is held invalid, then the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end the provisions of this act are severable.

SECTION 3. For purposes of promulgating rules and initiating the procurement process, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect July 1, 2019, the public welfare requiring it.