STATE OF TENNESSEE

PUBLIC CHAPTER NO. 611

HOUSE BILL NO. 2289

By Representatives Curt Cobb, Mike Turner

Substituted for: Senate Bill No. 2239

By Senators Kyle, Stewart, Henry, Ford

AN ACT to amend Tennessee Code Annotated, Title 33; Title 56; Title 63; Title 68 and Title 71, relative to health care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-6-704(a), is amended by inserting the language “and the national committee for quality assurance (NCQA)” in the second sentence after the language “(URAC)” and before the language “if the agent”.

SECTION 2. Tennessee Code Annotated, Section 56-6-704(c), is amended by inserting the language “or the national committee for quality assurance (NCQA).” at the end of the second sentence following the language, “(URAC)”.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 2, Part 1, is amended by adding the following language as a new section.

§ 56-2-125.

(a) As used in this section, unless the context requires otherwise:

(1) "All payer claims database" means a database comprised of health insurance issuer and group health plan claims information that excludes the data elements in 45 C.F.R. § 164.514(e)(2);

(2) “Commissioner” means the commissioner of commerce and insurance;

(3) “Department” means the department of commerce and insurance;

(4) “Group health plan” means an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974 ("ERISA") § 3(1), codified in 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 such a plan. For purposes of this

section, “group health plan” shall not mean any plan which is offered through a health insurance issuer;

(5) “Health insurance coverage” means health insurance coverage as defined in § 56-7-2902(13) as well as medicare supplemental health insurance; and

(6) “Health insurance issuer” means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, 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. In addition, a “health insurance issuer” also means a pharmacy benefits manager, a third party administrator, and an entity described in § 56-2-121.

(b)

(1) The commissioner shall establish and maintain an all payer claims database to enable the commissioner of finance and administration to carry out the following duties:

(A) Improving the accessibility, adequacy, and affordability of patient health care and health care coverage;

(B) Identifying health and health care needs and informing health and health care policy;

(C) Determining the capacity and distribution of existing health care resources;

(D) Evaluating the effectiveness of intervention programs on improving patient outcomes;

(E) Reviewing costs among various treatment settings, providers, and approaches; and

(F) Providing publicly available information on health care providers’ quality of care.

(2) Nothing in this section shall preclude a health insurance issuer from providing information on health care providers' quality of care in accordance with § 56-32-130(e).

(c) There is hereby established a Tennessee health information committee, hereinafter also referred to as "the committee". The commissioner of finance and administration shall give all consideration to policies and recommendations formed by the committee, including those formed by the committee on any issues in response to a request of the commissioner of finance and administration in the commissioner's

discretion. Any recommendations developed by the committee shall, to the largest extent possible, be consistent with those of nationally recognized standard setting and accrediting bodies.

(1)

(A)

(i) The public release of any report utilizing data derived from the all payer claims database on quality, effectiveness, or cost of care of health care providers or provider shall require a two-thirds affirmative vote of the committee members present.

(ii) Health insurance issuers that contribute data to the all payer claims database and providers who are subjects of reports on quality, effectiveness, or cost of care, that utilize data derived from the all payer claims database shall be given access to such reports sixty (60) days prior to the public release of such reports for the review and submission of comments prior to such public release.

(B) Any other committee action shall require a simple majority affirmative vote of the committee members present.

(C) Neither the committee nor the commissioner is authorized to make public release of individual patient level claims data.

(2) The committee shall develop for the commissioner of finance and administration:

(A) A description of the data sets, based on national standards, if and when available, that will be included in the all payer claims database; and

(B) A method for submission of data.

(3) The committee shall develop for the commissioner of finance and administration security measures for ensuring compliance with:

(A) The federal requirements of the Health Insurance Portability and Accountability Act of 1996, compiled in 42 U.S.C. § 1320d et seq. (“HIPAA”), and implementing federal regulations; and

(B) Other state and federal privacy laws.

(4) The committee shall regularly evaluate the integrity and accuracy of the all payer claims database.

(5) The committee shall develop policies to make reports from the all payer claims database available as a resource for insurers, employers, providers, and purchasers of health care, to continuously review health care utilization, expenditures, and performance in this state. Such uses shall be subject to restrictions required by HIPAA and other applicable privacy laws and policies as well as to reasonable charges recommended by the committee and set by rule.

(6) The committee shall be chaired by the commissioner of finance and administration or designee and attached to the department of finance and administration for administrative purposes. The committee members shall serve without compensation and travel expenses.

(7)

(A) The committee shall include:

(i) The commissioner or designee;

(ii) The commissioner of health or designee;

(iii) The commissioner of mental health and developmental disabilities or designee;

(iv) The commissioner of finance and administration or designee;

(v) The director of the state division of health planning or equivalent;

(vi) The director of the office of e-health initiatives or equivalent; and

(vii) The deputy commissioner of the bureau of TennCare or designee.

(B) The committee shall include the following members to be appointed by the commissioner of finance and administration:

(i) Two (2) physician members. The Tennessee Medical Association is authorized to submit to the commissioner a list of nominees from which the physicians may be selected;

(ii) Two (2) members to represent hospitals. The Tennessee Hospital Association and the Hospital Alliance of Tennessee are authorized to submit to the commissioner a list of nominees from which the representative may be selected;

(iii) One (1) pharmacist member. The Tennessee Pharmacists Association is authorized to submit to the commissioner a list of nominees from which the pharmacists may be selected;

(iv) Two (2) members to represent the health insurance industry;

(v) One (1) member to represent a hospital and medical service corporation;

(vi) One (1) member to represent a coalition of businesses who purchase health services;

(vii) One (1) member to represent a self-insured employer;

(viii) One (1) member to represent health care consumers; and

(ix) One (1) member to represent ambulatory surgical treatment centers.

(8) The committee may appoint one (1) or more subcommittees to provide advice and recommendations related to the operations and use of the all payer claims database, including but not limited to advisory committees on:

(A) Research;

(B) Technology;

(C) Participation by health insurance issuers in the all payer claims database; and

(D) Such other matters as the committee may approve in its discretion.

(9) The members of the Tennessee health information committee appointed by the commissioner of finance and administration as provided in subdivision (7)(B) shall serve one-year terms and shall be eligible for reappointment to subsequent terms; provided, however, that five (5) of the initial members shall

serve an initial term of two (2) years. Vacancies shall be filled for any unexpired terms, and members shall serve until their successors are appointed. The initial term of such members shall be deemed to commence on July 1, 2009.

(10) The committee shall terminate on June 30, 2011, pursuant to § 4-29-232(b). The committee may be continued, reestablished or restructured in accordance with title 4, chapter 29.

(d)

(1) As required by HIPAA, the all payer claims database shall not publicly disclose any individually identifiable health information as defined in 45 C.F.R. § 160.103. Use of the all payer claims database shall be subject to restrictions required by HIPAA and other applicable privacy laws and policies. The all payer claims database shall be accessed only by staff or a designated entity authorized in writing by the commissioner of finance and administration to perform the analyses contemplated by this section. The commissioner shall collaborate with the Tennessee health information committee in developing procedures and safeguards to protect the integrity and confidentiality of any data contained in the all payer claims database.

(2)

(A) 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, unless public release of reports is authorized by the Tennessee Health Information Committee; and other information submitted under this section, whether in electronic or paper form:

(i) Shall not be considered a public record and shall not be open for inspection by members of the public under § 10-7-503(a)(1). Further, such information contained in the all payer claims database shall be considered confidential and not subject to subpoena; and

(ii) Reports derived from any such information shall only be released pursuant to rules adopted by the commissioner subsequent to consultation with the Tennessee health information committee. Any release of reports shall not result in such information losing its confidentiality or cause it to be admissible, except in administrative

proceedings authorized under the rules adopted by the commissioner.

(B) The commissioner shall, through memoranda of understanding and after consultation with the Tennessee health information committee, 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 developmental disabilities, and other departments of state government for the purposes listed in subdivision (b)(1).

(C) Except for officials of the state or such officials' designees as permitted by subsection (d)(1), nothing within this section shall be construed as permitting access to or discovery of the source or draft information used to construct or populate the all payer claims database.

(e) The all payer claims database shall contain unique health care provider identifiers that may be used in public reports; provided, however that no information that could reveal the identity of any patient from the all payer claims database shall be made available to the public. To ensure that individual patients are not identified, the following data shall not be included in any transmission by a group health plan or health insurance issuer to the state or designated entity for the all payer claims database or in any source or draft information used to construct or populate the all payer claims database:

(1) Patient names;

(2) Patient street addresses;

(3) All elements of patient birth dates, except year of birth;

(4) Patient telephone numbers;

(5) Patient facsimile numbers;

(6) Patient electronic mail addresses;

(7) Patient social security numbers;

(8) Medical record numbers;

(9) Health plan beneficiary numbers;

(10) Patient account numbers;

(11) Patient certificate/license numbers;

(12) Vehicle identifiers and serial numbers including license plate numbers;

(13) Device identifiers and serial numbers;

(14) Web universal resource locators (URLs);

(15) Internet protocol (IP) address numbers;

(16) Biometric identifiers including fingerprints, voiceprints, and genetic code;

(17) Full-face photographic images and any comparable images; or

(18) Any other unique patient identifying number, characteristic, or code except encrypted index numbers assigned prior to the transmission by group health plans or health insurance issuers to the state or designated entity for the purpose of linking procedures by patient, provided a patient's identity cannot be known from the encrypted index number.

(f)

(1)

(A) No later than January 1, 2010, and every month thereafter, all group health plans and health insurance issuers shall provide electronic health insurance claims data for state residents to the commissioner or a designated entity authorized by the commissioner, in accordance with standards and procedures recommended by the Tennessee health information committee pursuant to subdivision (c)(2) and adopted by the commissioner by rule.

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

(C) The Tennessee health information committee and the commissioner shall strive for standards and procedures that are the least burdensome for data submitters.

(2) The collection, storage, and release of health and health care data and statistical information that is subject to the

federal requirements of HIPAA shall be governed by the rules adopted in 45 C.F.R. 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 commissioner 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 commissioner on a timely basis, the commissioner may impose a civil penalty of up to one hundred dollars ($100) for each day of delay.

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

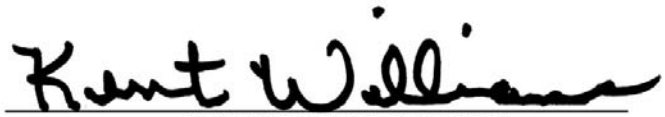
(h)

(1) The commissioner may, subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, promulgate rules and regulations for purposes of implementing this section. The commissioner is authorized to promulgate the initial rules as public necessity rules pursuant to § 4-5-209 prior to January 1, 2010 for the purpose of creating the all payer claims database.

(2) The commissioner of finance and administration may, subject to the Uniform Administrative Procedures Act compiled in title 4, chapter 5, promulgate rules and regulations concerning the operation of the all payer claims database and the distribution and use of information maintained or created thereby. The commissioner of finance and administration is authorized to promulgate the initial rules as public necessity rules pursuant to § 4-5-209 prior to January 1, 2010, for the purpose of creating the all payer claims database.

SECTION 4. This act shall take effect upon becoming law, the public welfare requiring it.

PASSED: June 18, 2009



KENT WILLIAMS, SPEAKER
HOUSE OF REPRESENTATIVES

RON RAMSEY
SPEAKER OF THE SENATE

APPROVED this 9th day of July 2009

PHIL BREDESEN, GOVERNOR