# STATE OF CONNECTICUT

*INSURANCE DEPARTMENT*

**BULLETIN No. HC – 78**
**June 17, 2010**

**TO:** All Health Insurers and Health Care Centers Authorized to Conduct Group Health Insurance Business in Connecticut

**SUBJECT:** Connecticut Public Act No. 10-163
An Act Concerning Transparency in Health Insurance Claims Data

The Connecticut Insurance Department is providing the following information to licensed health insurers and health care centers with respect to fully insured group health insurance policies issued in Connecticut to the following public entities: towns, cities, boroughs, school districts, taxing districts, and fire districts employing more than 50 employees.

Public Act No. 10-163 is effective June 7, 2010.This Act permits a public entity listed above to request specific health insurance claims data related to its plan, as specified in the law, from its existing health insurer or health care center. The public entity may only use the information for the purposes of obtaining competitive quotes for group health insurance or to promote wellness initiatives for its employees. In addition, the public entity is required to share claim information with an employee organization that is the exclusive bargaining representative of the entity's employees, when requested, in order for the public entity to meet its Connecticut statutory obligation to bargain collectively.

Most of the terms of the new Public Act (copy attached) are reasonably clear on their face, but in response to inquiries, the Department would like to provide the following guidance on 3 specific issues:

(1) Public Entity Employing more than 50 Employees

The law applies to a public entity employing (emphasis added) 50 or more employees. A health insurer or health care center must comply with a request pursuant to the law if the public entity employs 50 or more employees. The number of employees eligible for group health insurance coverage or enrolled in group health insurance coverage is irrelevant.

(2) Claims Data Goes to Employer

Under the law the health insurer or health care center is to provide the claims information to the employer/public entity. Health insurers and health care centers meet their obligations by providing the information solely to the employer/public entity. In turn, the employer shall then forward claims data to the bargaining representative for the employees, upon request, consistent with the law's requirements.

The Department does not interpret the law to require the health insurer or health care center to provide the claims information to brokers or other parties who may be assisting the public entities in their efforts to (i) obtain competitive quotes or (ii) promote wellness initiatives. Rather, the health insurer or health care center, under the terms of the law, is to provide the claim information to the employer. The employer may then evaluate

sharing the data, as necessary and appropriate, with brokers or other parties assisting the employer with either of the 2 specified efforts, pursuant to what contracts the employer may have in place with such vendors, including confidentiality provisions.

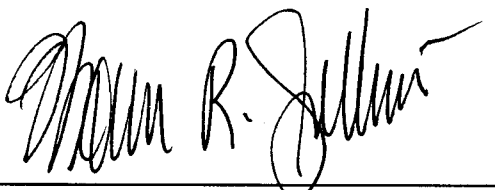
The law does not specify a time period in which the health insurer or health care center is to supply the claims data. However, the Department expects health insurers and health care centers to respond to such requests on a timely basis, as soon as commercially reasonable.

(3) Privacy

The Public Act in section 1(b)(2) indicates that the health insurer or health care center is to provide the employer with the specified health insurance information that (i) has had identifiers removed, pursuant to federal privacy regulations, (ii) is not individually identifiable under federal privacy regulations, and (iii) is permitted to be disclosed under the federal Health Insurance Portability and Account Act (HIPAA). The Department's position is that health insurers and health care centers should not attempt to take a very conservative approach with respect to (iii) above, to restrict data provided to public entities. The Department believes the legislative requirements in (i) and (ii) above are intended to, and do indeed, resolve privacy concerns. However, the Department is also aware that, with employer groups just above the 50 employee threshold, it may be possible for an employer, due to the low volume of data, to determine the identity of the employee to which certain data relates. In such limited circumstances, the health insurer or health care center may contact to the Department and indicate its concern. In appropriate circumstances, the health insurer or health care center may seek an authorization from the employee to whom the information (even though de-identified) applies. However, any such situations are to be handled in a case by case basis, after discussion with the Department's legal staff.

**Questions**

Please contact the Insurance Department Consumer Affairs Division at cid.ca@ct.gov or at 800-203-3447 or 860-297-3900 with any questions.



Thomas R. Sullivan
Insurance Commissioner

## *Public Act No. 10-163*

### *AN ACT CONCERNING TRANSPARENCY IN HEALTH INSURANCE CLAIMS DATA.*

Section 1.(a) As used in this section:

(1) "Claims paid" means the amounts paid for the covered employees of an employer by an insurer, health care center, hospital service corporation, medical service corporation or other entity as specified in subsection (b) of this section for medical services and supplies and for prescriptions filled, but does not include expenses for stop-loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features, administrative costs or profit.

(2) "Employer" means any town, city, borough, school district, taxing district or fire district employing more than fifty employees.

(3) "Utilization data" means (A) the aggregate number of procedures or services performed for the covered employees of the employer, by practice type and by service category, or (B) the aggregate number of prescriptions filled for the covered employees of the employer, by prescription drug name.

(b) Each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall:

(1) Disclose to an employer sponsoring such policy, upon request by such employer, the following information for the most recent thirtysix-month period or for the entire period of coverage, whichever is shorter, ending not more than sixty days prior to the date of the request, in a format as set forth in subdivision (3) of this subsection:

(A) Complete and accurate medical, dental and pharmaceutical utilization data, as applicable;

(B) Claims paid by year, aggregated by practice type and by service category, each reported separately for in-network and out-of-network providers, and the total number of claims paid;

(C) Premiums paid by such employer by month; and

(D) The number of insureds by coverage tier, including, but not limited to, single, two-person and family including dependents, by month;

(2) Include in such requested information specified in subdivision (1) of this subsection only health information that has had identifiers removed, as set forth in 45 CFR 164.514, is not individually identifiable, as defined in 45 CFR 160.103, and 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; and
(3) Disclose such requested information (A) in a written report, (B) through an electronic file transmitted by secure electronic mail or a file transfer protocol site, or (C) through a secure web site or web site portal that is accessible by such employer.
(c) Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall not be required to provide such information to the employer more than once in any twelve-month period.
(d) Information disclosed to an employer pursuant to this section shall be used by such employer only for the purposes of obtaining competitive quotes for group health insurance or to promote wellness initiatives for the employees of such employer.
(e) Any information disclosed to an employer in accordance with this section shall not be subject to disclosure under section 1-210 of the general statutes. An employee organization, as defined in section 7-467 of the general statutes, that is the exclusive bargaining representative of the employees of such employer shall be entitled to receive claim information from such employer in order to fulfill its duties to bargain collectively pursuant to section 7-469 of the general statutes.
(f) If a subpoena or other similar demand related to information disclosed pursuant to this section is issued in connection with a judicial proceeding to an employer that receives such information, such employer shall immediately notify the insurer, health care center, hospital service corporation, medical service corporation or other entity that disclosed such information to such employer of such subpoena or demand. Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall have standing to file an application or motion with the court of competent jurisdiction to quash or modify such subpoena. Upon the filing of such application or motion by such insurer, health care center, hospital service corporation, medical service corporation or other entity, the subpoena or similar demand shall be stayed without penalty to the parties, pending a hearing on such application or motion and until the court enters an order sustaining, quashing or modifying such subpoena or demand.