

# DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT Division of Insurance

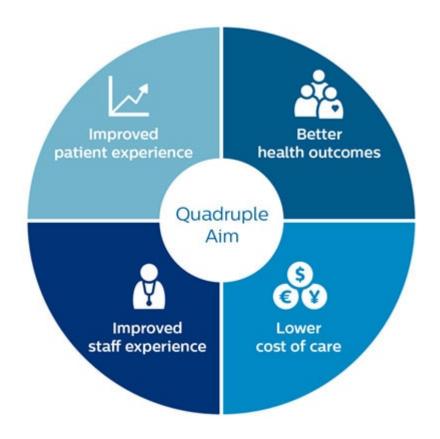
### CSSB 93

"An Act relating to the establishment of an all-payer claims database"

Senate Finance
Lori Wing-Heier, Director
April 29, 2021



# Health Care – Quadruple Aim



### **Broad Community Involvement**

- Administration and the Legislature
- Congressional delegation
- Tribal partners
- Chamber of Commerce and other business organizations
- Alaska Healthcare Transformation Project
- Alaskans for Sustainable Healthcare Costs
- Alaska Policy Forum
- Mat-Su Health Foundation
- Municipalities, School Districts, and Universities
- Insurance companies and insurance brokers
- Providers



# What is missing? Organized, succinct data



#### Sources of Data

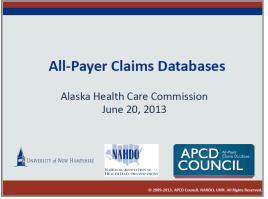
- AlaskaCare
- Medicaid
- Medicare
- Insurance Companies
- Third-Party Administrators
- Trusts and other Self-Insured Plans

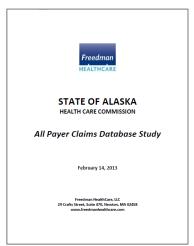


Many Reports - No Data

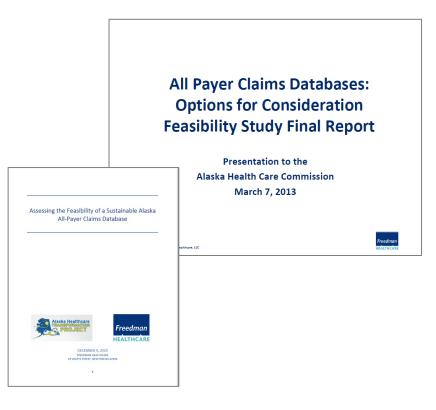


### Alaska Health Care Commission and others











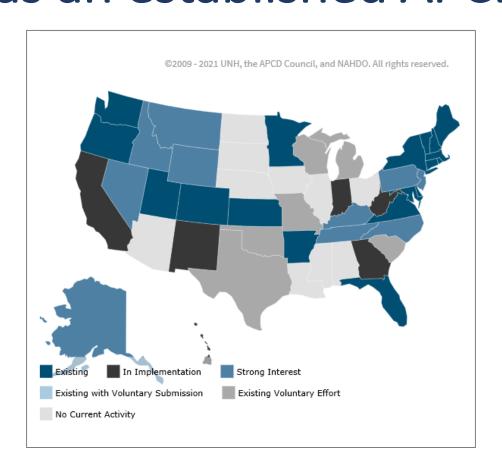
## What is an All Payer-Claims Data Base?

An All-Payer Claims Data Base (APCD) is a large database that includes medical, pharmaceutical, and dental claims. These databases are hosted, directly or through a contract, by states.

Public (i.e. Medicaid) and private payors (i.e. insurance companies and third-party adjusters) submit the data, in a pre-determined standard format, to the state.



### Who has an established APCD?





### If not now, when? If not us, who?

If we are to continue with our partners, towards the Quadruple Aim of Health Care – we need to take the first step.

And the No Surprise Bill Act under the Consolidated Appropriation Act of 2021 – just gave us a gentle nudge.



# 2020 No Surprise Bill

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DECEMBER 21 . 2020

RILES COMMITTEE PRINT 116-68

TEXT OF THE HOUSE AMENDMENT TO THE

SENATE AMENDMENT TO H.R. 133

[Showing the text of the Consolidated Appropriations Act,

In lieu of the matter proposed to be inserted by the

Senate, insert the following:

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the "Consolidated Appro-

3 priations Act, 2021".

4 SEC. 2. TABLE OF CONTENTS.

DIVISION B—COMMERCE, JUSTICE, SCIENCE, AND RELATED AGENCIES APPROPRIATIONS ACT, 2021

Over 5,500 pages.....

U.2009 LOMNING ACMINING APP and

1 DIVISION BB-PRIVATE HEALTH 2 INSURANCE AND PUBLIC

HEALTH PROVISIONS

4 SEC. 1. TABLE OF CONTENTS.

5 The table of contents of the division is as follows: DIVISION BB—PRIVATE HEALTH INSURANCE AND PUBLIC HEALTH PROVISIONS

Sec. 101. Short tithis.

Sec. 102. Health insurance requirements regarding surprise medical billing.

Sec. 103. Determination of out-of-network rates to be paid by health plans;

In Determination of out-of-network rates to be paid by health plans;

In Determination of out-of-network regarding surprise medical billing.

Sec. 105. Ending surprise als architecture but for the plans of the plans

ec. 100., Institute surprise air ammuniation tomo.

ec. 106. Reporting requirements regarding air ambulance services.

foc. 107. Transparency regarding in-network and out-of-network deductibles
and out-of-pocket limitations.

ec. 108. Implementing protections against provider discrimination.

Sec. 112. Patient protections through transparency and patient-provider dis-

Sec. 112. Patient protections through transparency and patient-provider dis-position of the patient protection. Sec. 113. Ensuring continuity of care.
Sec. 114. Maintenance of price occuparison tool.
Sec. 115. State All Paper Chains Databassos.
Soc. 116. Protecting patients and improving the assurancy of provider directory

TITLE II—TRANSPARENCY

Sec. 201. Increasing transparency by removing gag clauses on price and quality

information.

Sec. 2022. Discharge of direct and indirect compensation for brokers and consistant to employer-opensored builth plans and enveloes in plans on the individual nariest.

Sec. 203. Strengthening parity in montal health and substance use disorder benefits.

Sec. 204. Beperling on planmacy benefits and drag costs.

TITLE III-PUBLIC HEALTH PROVISIONS

December 21, 2020 (7:54 a.m.)

(1) by redesignating subsection (e) as sub-

DISPUTE RESOLUTION PROCESS.

4 (a) PHSA.—Section 2799A-1, as added by section

1741 1 SEC. 103. DETERMINATION OF OUT-OF-NETWORK RATES TO

BE PAID BY HEALTH PLANS; INDEPENDENT

(2) by inserting after subsection (b) the following new subsection:

"(e) Determination of Out-of-network Rates

11 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE

"(1) DETERMINATION THROUGH OPEN NEGO-

"(A) IN GENERAL.—With respect to an item or service furnished in a year by a non-

participating provider or a nonparticipating facility, with respect to a group health plan or

health insurance issuer offering group or individual health insurance coverage, in a State de-

to such plan or coverage and provider or facility, and for which a payment is required to be

made by the plan or coverage pursuant to sub-

section (a)(1) or (b)(1), the provider or facility

(as applicable) or plan or coverage may, during

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1 2, section 716 or 717 of the Employee Retirement Income 2 Security Act of 1974, or section 9816 or 9817 of the In-

3 ternal Revenue Code of 1986, including with respect to

4 whether an item or service that is the subject to such a

5 determination is an item or service to which such respec-

6 tive section applies.

7 (b) Definitions.—The terms "group health plan";

8 "health insurance issuer"; "group health insurance cov-9 erage", and "individual health insurance coverage" have

10 the meanings given such terms in section 2791 of the Pub-

11 lie Health Service Act (42 U.S.C. 300gg-91), section 733 12 of the Employee Retirement Income Security Act (29

13 U.S.C. 1191b), and section 9832 of the Internal Revenue

15 SEC. 111. CONSUMER PROTECTIONS THROUGH HEALTH PLAN REQUIREMENT FOR FAIR AND HONEST

ADVANCE COST ESTIMATE.

18 (a) PHSA AMENDMENT.—Section 2799A-1 of the 19 Public Health Service Act (42 U.S.C. 300gg-19a), as

20 added by section 102 and as further amended by the pre-

21 vious provisions of this title, is further amended by adding 22 at the end the following new subsection:

23 "(f) ADVANCED EXPLANATION OF BENEFITS ....

"(1) IN GENERAL.—For plan years beginning

25 on or after January 1, 2022, each group health

13 Service Act, as added by section 102(a) and amended by

14 section 103, is further amended by adding at the end the 15 following new subsection:

OF POCKET LIMITATIONS

12 (a) Phsa.—Section 2799A-1 of the Public Health

1 graph (4). The Committee may update such report,

3 (h) Definitions.—In this section, the terms "group

4 health plan", "health insurance coverage", "individual 5 health insurance coverage", "group health insurance cov-

6 erage", and "health insurance issuer" have the meanings

7 given such terms in section 2791 of the Public Health

9 SEC. 107. TRANSPARENCY REGARDING IN.NETWORK AND

OUT-OF-NETWORK DEDUCTIBLES AND OUT-

8 Service Act (42 U.S.C. 300gg-91).

2 as determined appropriate by the Committee

16 "(e) Transparency Regarding In-Network and 17 Out-of-network Deductibles and Out-of-pocket

18 LIMITATIONS.—A group health plan or a health insurance

19 issuer offering group or individual health insurance cov

20 erage and providing or covering any benefit with respect

21 to items or services shall include in clear writing on any 22 physical or electronic plan or insurance identification card

23 issued to the participants, beneficiaries, or enrollees in the

24 plan or coverage the following:

1 SEC 115 STATE ALL DAVED CLAIMS DATABASES

2 (a) Grants to States.—Part B of title III of the 3 Public Health Service Act (42 U.S.C. 243 et seq.) is

4 amended by adding at the end the following:

5 "SEC. 320R. STATE ALL PAYER CLAIMS DATABASES.

6 "(a) IN GENERAL.—The Secretary shall make one 7 time grants to eligible States for the purposes described

9 "(b) USES.—A State may use a grant received under 10 subsection (a) for one of the following purposes:

"(1) To establish a State All Payer Claims

"(2) To improve an existing State All Payer

15 "(e) ELIGIBILITY.—To be eligible to receive a grant 16 under subsection (a), a State shall submit to the Secretary

17 an application at such time, in such manner, and con-

18 taining such information as the Secretary specifies, includ-19 ing, with respect to a State All Payer Claims Database

20 at least specifies on how the State will ensure uniform 21 data collection and the privacy and security of such data.

22 "(d) Grant Period and Amount ... Grants award-23 ed under this section shall be for a period of 3-years, and

24 in an amount of \$2.500,000, of which \$1.000,000 shall 25 be made available to the State for each of the first 2 years



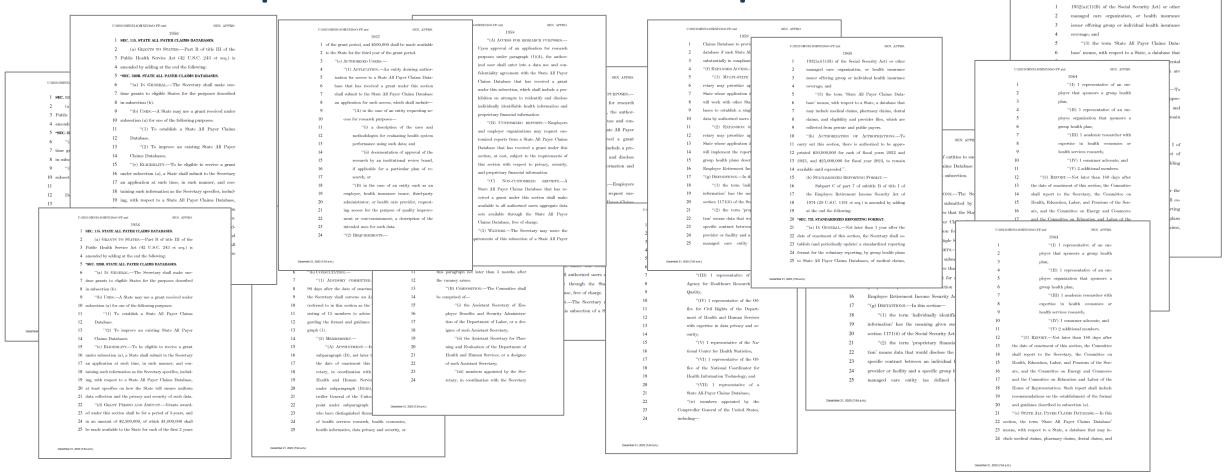
### What the No Surprise Bill provides:

- Provides a structure to protect consumers against surprise medical bills and determining out-of-network provider payments including air ambulances
- Notice and consent provisions for balance billing of non-emergency services by nonparticipating providers at participating facilities
- Establishes requirements for provider directories

- Establishes a dispute resolution process for uninsured
- Provides guidance for continuity of care
- Requires insurers and other plans to have a price comparison tool
- Modifies requirement on insurance cards
- Requires plans to provide an advance explanation of benefits
- Encourages All-Payer Claims Databases and provides grants up to \$2.5 million to each state



An APCD provision in the No Surprise Bill



## APCD – Grants - \$2.5 million

The state shall submit an application, containing such information as the Secretary specifies including how the state will ensure uniform data collection and the privacy and security of data.



### **Authorized Users**

An entity wanting access to the APCD, that has received a grant, shall submit to the State APCD an application for such access which shall include:

- In the case of an entity requesting access for research purposes a description of the uses and methodologies for evaluating health system performance using the APCD; and
- Documentation of approval of the research by an institutional review board, if applicable for a particular plan or research
- The entity shall enter into a data use and confidentiality agreement with the state – the agreement shall include a prohibition on attempts to reidentify and disclose individually identifiable health information and proprietary financial information

- If the entity is an employer, health insurance company, third-party administrator, or health care provider requesting access for the purpose of quality improvement or cost-containment, a description of the intended use of the data.
- Employers and employer organizations may request customized reports, at cost, subject to the requirements of privacy, security, and proprietary financial information.
- The state shall make available, to all eligible users, aggregate data sets free of charge.



### Standardized format

The Secretary shall establish, and periodically update, a standardized reporting format for voluntary reporting, by group health plans of:

- Medical claims;
- Pharmacy claims;
- Dental claims;
- Eligibility; and
- Provider files



#### CSSB93 – Sectional Analysis

**Section 1** Establishes a new chapter 92 in Title 21 with the following sections:

Section 21.92.010 – All-payer claims database (APCD) is established.

- (a) Defines the purpose of a statewide APCD:
  - 1) collect and analyze existing health care cost and quality data;
  - 2) create a central repository that is objective and reliable;
  - provide transparent access to health care information while protecting individual privacy and proprietary data; and
  - 4) enable researchers, policymakers, and the public to make informed decisions regarding health care.
- (b) APCD must provide:
  - 1) publishable analytics to improve transparency;
  - 2) systematic collection of data; and
  - 3) enhanced transparency.
- (c) The director may:
  - 1) require an insurer to submit data;
  - 2) establish penalties to ensure compliance;
  - 3) create agreements for voluntary reporting;
  - 4) solicit, receive and administer funding from public and private sources;
  - (5) establish, by regulation, a schedule of reasonable fees to be charged to an authorized requestor that is a business entity for the use and distribution of data from the database to the business entity; and
  - 6) carry out other activities.

#### Section 21.92.020 – Selection and duties of lead organization.

- (a) By competitive bid, the director shall select an organization to manage the APCD.
- (b) The selected organization shall:
  - apply to be certified as a qualified entity under 42 C.F.R. 401.703(a) by the Centers of Medicare and Medicaid:
  - enter into a contract with a data vendor or multiple data vendors to perform data collection, processing, aggregation, extracts, and analytics;
  - 3) be responsible for internal governance, management, and operations of the database;
  - 4) engage stakeholders in the development and maintenance of the database;
  - 5) provide an annual report to the director regarding the status of the database and any recommendations for change;
  - establish a process for making claims and other data from the database available for use and distribution upon request to authorized users;
  - engage consumer protection stakeholders and the community in the process to ensure claims and other data from the database are available in a format accessible to all authorized requesters;
  - prepare a health care data report each calendar year that aggregates and analyzes the data submitted to the database; and
  - 9) perform other duties as required by the director to fulfill the purposes of this chapter.

#### Section 21.92.030 - Confidentiality.

- (a) The APCD shall be secure and confidential and shall not be subject to public records public inspection. Aggregated information can be shared as provided in regulations. Individually identifiable health care information will be confidential; and
- (b) Information in the database will not be subject to subpoena in any civil, criminal, judicial, or administrative proceeding.

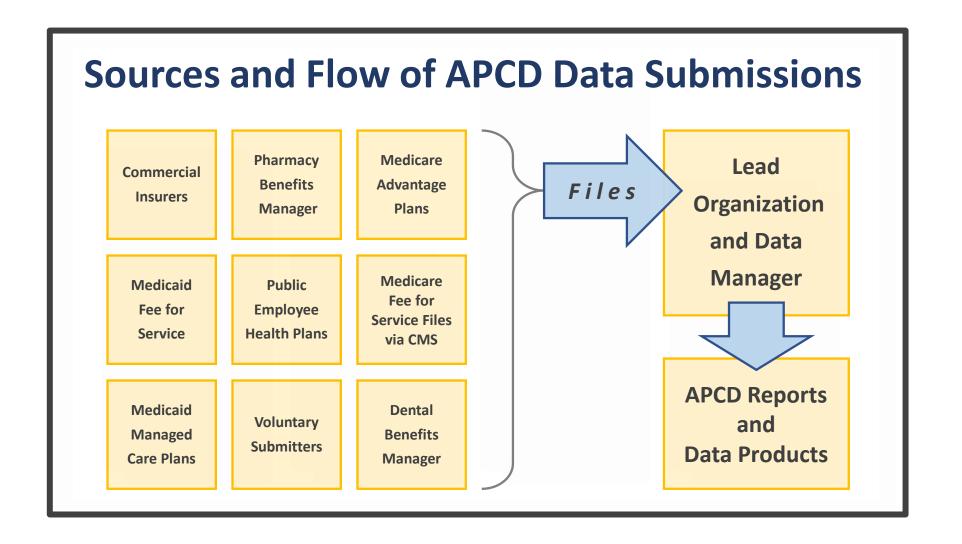
#### Section 21.92.040 – Eligibility for state grants

- (a) A health care insurer that is required to submit health care data to the statewide all-payer claims database may not receive a state grant unless the insurer submits the data as required in AS 21.92.010.
- (b) A health care payer that is required to submit health care data to the statewide all-payer claims database may not receive a state grant unless the insurer submits the data as required in AS 21.92.010.

#### Section 21.92.040 – Regulations.

Allows for the director of the Division of Insurance to adopt regulations.





## Nearly 70% of Alaskans Covered

Table 1: Types of Coverage

Type of Coverage	Covered Lives	% of Alaska Population
Medicaid and CHIP	235,000	32%
Medicare FFS	104,000	14%
Dual Eligibles'	(18,000)	(2%)
Fully Insured Commercial Plans	60,000	8%
State Employee Plans	114,000	16%
Total (minus Dual Eligibles to avoid double counting)	498,000	68%

<sup>&</sup>lt;sup>1</sup> Dual eligible lives may be counted in multiple categories; this adjustment avoids double counting of approximately 18,000 Alaskans who are eligible for both Medicare and Medicaid.

# **Key Tasks and Timing**

#### **FOUNDATIONAL**

#### Year 1

#### State

- · Regulatory action
- Contracting
- Funding

#### State and Local NP

- · Stakeholder engagement
- · Reporting plan

#### **START-UP**

#### Year 2

LO with State Oversight

- · Submitter Outreach
- · Registration
- · Historical Data
- · Current Data
- · Policies

#### **OPERATIONS**

#### Year 3

LO with State Oversight

- · Processing
- · Advanced DQ
- · Enhancements
- · Data Access
- · Website

# Thank you!