§ 56-2-125. Health information committee; members; duties; payer claims database: General Requirements for Doing Business

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

(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 CFR 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 § 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. For purposes of this section, “group health plan” shall not mean any plan that is offered through a health insurance issuer;

(5) “Health insurance coverage” means health insurance coverage as defined in § 56-7-2902, 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. “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).

(d)(1) As required by HIPAA, the all payer claims database shall not publicly disclose any individually identifiable health information as defined in 45 CFR 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 develop procedures and safeguards to protect the integrity and confidentiality of any 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 section, whether in electronic or paper form, 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). The information contained in the all payer claims database shall be considered confidential and not subject to subpoena.

(ii) The commission may promulgate rules to authorize the public release of reports derived from the information. 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, 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, and other departments of state government for the purposes listed in subdivision (b)(1).

(C) Except for officials of the state or those officials' designees as permitted by subdivision (d)(1), nothing in 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, that 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 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 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 emergency rules pursuant to the Uniform Administrative Procedures Act 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, 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 emergency rules pursuant to the Uniform Administrative Procedures Act prior to January 1, 2010, for the purpose of creating the all payer claims database.