House of Representatives

General Assembly

File No. 615

January Session, 2009

Substitute House Bill No. 6600

House of Representatives, April 14, 2009

The Committee on Public Health reported through REP. RITTER of the 38th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2009*) As used in sections 1 to 18, inclusive, 20 to 22, inclusive, and 24 to 26, inclusive, section 17b-297b of the general statutes, as amended by this act, and subdivision (1) of section 1-120 of the general statutes, as amended by this act:

(1) "Authority" means the SustiNet Authority created by section 2 of this act or any board, body, commission, department or officer succeeding to the principal functions thereof or to whom the powers conferred upon the authority by sections 1 to 18, inclusive, 20 to 22, inclusive and 24 to 26, inclusive, shall be given by law;

(2) "SustiNet Plan" is a self-insured health care delivery plan, administered by the authority and operated by a public-private partnership, that is designed to ensure that plan enrollees receive high-quality health care coverage without unnecessary costs;

(3) "Federal poverty level" means the poverty income guidelines updated periodically by the United States Department of Health and Human Services under the authority of 42 USC 9902(2);

(4) "Standard benefits package" means a set of covered benefits, with out-of-pocket cost-sharing limits and provider network rules, subject to the same coverage mandates that apply to small group health insurance sold in this state. The standard benefits package includes the following:

(A) Coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical and occupational therapy; home health care; vision care; family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; the identification and treatment of developmental delays from birth through age three; and wellness programs, provided the authority approves such wellness programs after being presented with convincing scientific evidence that such programs are effective in reducing the severity or incidence of chronic disease;

(B) A per individual and per family deductible determined by the authority, provided preventive care or prescription drugs shall not be subject to any deductible;

(C) Preventive care requiring no copayment that includes well-child visits, well-baby care, prenatal care, annual physical examinations, immunizations and screenings;

(D) Office visits for matters other than preventive care for which there shall be a copayment as prescribed by the authority;

(E) Prescription drug coverage with copayments as determined by the authority for generic, name-brand preferred and name-brand nonpreferred drugs;

(F) Coverage of mental and behavioral health services, including tobacco cessation services, substance abuse treatment services, and

services that prevent and treat obesity with such services being at parity with the coverage for physical health services; and

(G) Dental care coverage that is comparable in scope to the median coverage provided to employees by large employers in the Northeast states; provided, in defining large employers, the authority may take into account the capacity of available data to yield, without substantial expense, reliable estimates of median dental coverage offered by such employers;

(5) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended from time to time;

(6) "Small employer" (A) means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within this state. "Small employer" includes a self-employed individual, a municipality procuring health insurance pursuant to section 5-259 of the general statutes, a private school in this state procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of such private schools, a nonprofit organization procuring health insurance pursuant to said section 5-259, an association for personal care assistants procuring health insurance pursuant to said section 5-259, or a community action agency procuring health insurance pursuant to said section 5-259. (B) In determining the number of eligible employees for purposes of subparagraph (A) of this subdivision, companies that are affiliated companies, as defined in section 33-840 of the general statutes, or that are eligible to file a combined tax return for purposes of taxation under chapter 208 of the general statutes shall be considered one employer and eligible employees shall not include employees covered through the employer by health insurance plans or insurance arrangements issued to or in

accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act. (C) Except as otherwise specifically provided, provisions of sections 12-201, 12-211, 12-212a and 38a-564 to 38a-572, inclusive, of the general statutes that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of subparagraph (A) of this subdivision;

(7) "Employer-sponsored insurance" means a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, as amended from time to time;

(8) "Electronic medical record" means a record of a person's medical treatment created by a licensed health care provider and stored in an interoperable and accessible digital format;

(9) "Electronic health record" means an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization;

(10) "Participating provider" means a licensed health care provider that agrees to provide nonemergency services to SustiNet members, pursuant to policies adopted by the authority;

(11) "SustiNet member" means an individual enrolled in the SustiNet Plan;

(12) "Northeast states" means the Northeast states as defined by the United States Census Bureau; and

(13) "Board" means the board of directors that governs the SustiNet Authority.

Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is created a body politic and corporate to be known as the "SustiNet Authority". Said authority is constituted a public instrumentality and political

subdivision of the state and the exercise by the authority of the powers conferred by this section shall be deemed and held to be the performance of an essential public and governmental function. The board of directors of said authority shall consist of nine members, seven of whom shall be appointed as follows: One appointed by the Governor, who shall be an expert on health economics; one appointed by the president pro tempore of the Senate, who shall be an expert on health care delivery, including primary care delivery; one appointed by the speaker of the House of Representatives, who shall be a representative of Medicaid and HUSKY Plan beneficiaries; one appointed by the majority leader of the Senate, who shall be a representative of the Connecticut Hospital Association; one appointed by the majority leader of the House of Representatives, who shall be a representative of the Connecticut State Medical Society; one appointed by the minority leader of the Senate, who shall be a representative of the Connecticut Nurses' Association; and one appointed by the minority leader of the House of Representatives, who shall be a representative of private employers; two appointed by the coalition committee established pursuant to subsection (f) of section 5-278 of the general statutes, one of whom shall be a representative of labor unions and one of whom shall be a representative of business management. The Commissioners of Social Services, Public Health, and Mental Health and Addiction Services, the Insurance Commissioner and the Comptroller shall be ex-officio, nonvoting members of the board of directors.

(b) Initial appointments to the board of directors shall be made on or before August 15, 2009. (1) Board members appointed by the coalition committee shall serve at the pleasure of said committee. (2) The initial term for the board member appointed by the Governor and the president pro tempore of the Senate shall be for two years. The initial term for board members appointed by the speaker of the House of Representatives and the majority leader of the Senate shall be for three years. The initial term for board members appointed by the majority leader of the House of Representatives and the minority leader of the Senate shall be for four years. The initial term for the board member

appointed by the minority leader of the House of Representatives shall be for five years. Terms pursuant to this subdivision shall expire on June thirtieth in accordance with the provisions of this subdivision. Not later than thirty days prior to the expiration of a term as provided for in this subsection, the appointing authority may reappoint the current board member or shall appoint a new member to the board. Other than an initial term, a board member shall serve for a term of five years and until a successor board member is appointed. A member of the board pursuant to this subdivision shall be eligible for reappointment. (3) Any member of the board may be removed by the appropriate appointing authority for misfeasance, malfeasance or wilful neglect of duty. Each member of the board shall take and subscribe the oath or affirmation required by article XI, section 1, of the State Constitution prior to assuming such office. A record of each such oath shall be filed in the office of the Secretary of the State.

(c) The chairperson of the board shall be appointed by the Governor, with the advice and consent of both houses of the General Assembly. The board shall annually elect one of its members as vice chairperson. The board shall, within available appropriations, appoint an executive director, who shall not be a member of the board and shall serve at the pleasure of the board and receive compensation as determined by the board. Such compensation shall reflect the compensation typically paid in the private insurance industry for positions of comparable responsibility as determined by the board.

(d) The executive director shall supervise the administrative affairs and technical activities of the authority in accordance with the directives of the board. The executive director shall keep a record of the proceedings of the authority and shall be custodian of all books, documents and papers filed with the authority and of the minute book or journal of the authority and of its official seal. He may cause copies to be made of all minutes and other records and documents of the authority and may give certificates under the official seal of the authority to the effect that such copies are true copies, and all persons dealing with the authority may rely upon such certificates.

(e) The powers of the authority shall be vested in and exercised by the board of directors. Six of the voting members of the board shall constitute a quorum at any meeting of the board. No vacancy in the membership of the board shall impair the right of such members to exercise all the rights and perform all the duties of the board. Any action taken by the board under the provisions of sections 1 to 18, inclusive, 20 to 22, inclusive, and 24 to 26, inclusive, of this act may be authorized by resolution approved by a majority of the members present at any regular or special meeting, which resolution shall take effect immediately or by a resolution circulated or sent to each member of the board, which shall take effect at such time as a majority of the members shall have signed an assent to such resolution. Resolutions of the board shall be made publicly available through the Internet and through such other modalities as the board deems appropriate. Board meetings shall be open to the public, provided the board may meet in executive session, in accordance with chapter 14 of the general statutes, to discuss personnel and other proprietary matters. Notice of a board meeting and any agenda for such meeting shall be publicly available through the Internet and through such other modalities as the board deems appropriate. Board meetings shall be held from time to time in diverse localities throughout the state. The board shall invite public comment at all meetings and such comment shall be included in the record for such meeting. Public comment will be included in meeting records. The board may delegate by resolution to three or more of its members such powers and duties as it may deem proper. At least one of such members shall not be a state employee.

(f) Each member of the board shall execute a surety bond in the penal sum of fifty thousand dollars, and the executive director and the other officers of the authority shall execute a surety bond in the penal sum of one hundred thousand dollars, or, in lieu thereof, the chairman of the board shall execute a blanket position bond covering each member, the executive director and the employees of the authority, each surety bond to be conditioned upon the faithful performance of the duties of the office or offices covered, to be executed by a surety company authorized to transact business in this state as surety and to

be approved by the Attorney General and filed in the office of the Secretary of the State. The cost of each such bond shall be paid by the authority.

(g) The members of the board shall receive no compensation for the performance of their duties under this section but each such member shall be paid his necessary expenses incurred while engaged in the performance of such duties.

(h) Notwithstanding any provision of the general statutes, it shall not constitute a conflict of interest for a trustee, director, officer or employee of a health care institution, or for any person having a financial interest in such an institution, to serve as a member of the board of directors of the authority; provided such trustee, director, officer, employee or person shall abstain from deliberation, action and vote by the board under this sections 1 to 18, inclusive, 20 to 22, inclusive, and 24 to 26, inclusive, of this act in specific respect to the health care institution of which such member is a trustee, director, officer or employee or in which such member has a financial interest.

(i) The board of directors of the authority shall adopt written procedures, in accordance with the provisions of section 1-121 of the general statutes, for: (1) Adopting an annual budget and plan of operations, including a requirement of board approval before the budget or plan may take effect; (2) hiring, dismissing, promoting and compensating employees of the authority, including an affirmative action policy and a policy determining the extent to which board approval is required before a position may be created or a vacancy filled; (3) acquiring real and personal property and personal services, including a requirement of board approval for any nonbudgeted expenditure in excess of five thousand dollars; (4) contracting for financial, legal, insurance, underwriting and other professional services, including a requirement that the authority solicit proposals at least once every three years for each such service that it uses; (5) awarding loans, grants and other financial assistance, including eligibility criteria, the application process and the role played by the

authority's staff and board of directors; and (6) contracting with insurers or other entities for administrative purposes, such as claims processing and credentialing of providers.

(j) The authority shall not be construed to be a department, institution or agency of the state.

(k) The authority and any employee of the authority shall be subject to all ethical and auditing requirements as prescribed in chapter 12 of the general statutes.

Sec. 3. (NEW) (*Effective July 1, 2009*) (a) The purpose of the authority shall be to design and implement the SustiNet Plan. The SustiNet Plan shall be designed to (1) improve the health of state residents; (2) improve the quality of health care and access to health care; (3) provide health insurance coverage to Connecticut residents who would otherwise be uninsured; (4) increase the range of health care insurance coverage options available to residents and employers; and (5) slow the growth of per capita health care spending both in the short-term and in the long-term.

(b) The authority, within available appropriations, is authorized and empowered:

(1) To have perpetual succession as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business;

(2) To adopt an official seal and alter the same at pleasure;

(3) To maintain an office at such place or places as it may designate;

(4) To sue and be sued in its own name, and plead and be impleaded;

(5) To adopt guidelines, policies and regulations in accordance with chapter 54 of the general statutes that are necessary to implement the provisions of this section and sections 1 to 18, inclusive, 20 to 22,

inclusive, 24 to 26, inclusive, of this act;

(6) To invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state of Connecticut, including the Short Term Investment Fund, and the Tax-Exempt Proceeds Fund, and in other obligations which are legal investments for savings banks in this state, and in time deposits or certificates of deposit or other similar banking arrangements secured in such manner as the authority determines. The authority may delegate the investment powers provided in this subdivision to the State Treasurer;

(7) To employ professionals and agents as may be necessary in its judgment, and to fix their qualifications, duties and compensation;

(8) To contract with insurers or other entities for administrative purposes, such as claims processing and credentialing of providers. Such contracts shall reimburse these entities using "per capita" fees or other methods that do not create incentives to deny care. The selection of such insurers may take into account their capacity and willingness to (A) offer networks of participating providers both within and outside the state, and (B) help finance the administrative costs involved in the establishment and initial operation of the SustiNet Plan;

(9) To solicit bids from individual providers and provider organizations and to arrange with insurers and others for access to existing or new provider networks, and take such other steps to provide all SustiNet Plan members with excellent access to high-quality care throughout the state and, in appropriate cases, care that is outside the state's borders;

(10) To establish appropriate deductibles, minimum benefit packages and out-of-pocket cost-sharing levels for different providers, that may vary based on quality, cost, provider agreement to refrain from balance billing SustiNet Plan members, and other factors relevant to patient care and financial sustainability;

(11) To commission surveys of consumers, employers and providers on issues related to health care and health care coverage;

(12) To negotiate on behalf of providers participating in the SustiNet Plan to obtain discounted prices for vaccines and other health care goods and services;

(13) To make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under its enabling legislation, including contracts and agreements for such professional services as financial consultants, actuaries, bond counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, consultants, bio-ethicists and such other independent professionals or employees as the board of directors shall deem necessary;

(14) To purchase reinsurance or stop loss coverage, to set aside reserves, or to take other prudent steps that avoid excess exposure to risk in the administration of a self-insured plan;

(15) To enter into interagency agreements for performance of SustiNet Plan duties that may be implemented more efficiently or effectively by an existing state agency, including, but not limited to, the Department of Social Services and the office of the State Comptroller;

(16) To set payment methods for providers that reflect evolving research and experience both within the state and elsewhere, promote patient health, prevent unnecessary spending, and ensure sufficient compensation to cover the reasonable cost of furnishing necessary care;

(17) To arrange loans on favorable terms that facilitate the development of necessary health care infrastructure, including community-based providers of medical home services and community-based preventive care service providers;

(18) To arrange the offering of reduced price consultants that shall assist physicians and other health care providers in restructuring their

practices and offices so as to function more effectively and efficiently in response to changes in health care insurance coverage and the health care service delivery system that are attributable to the implementation of the SustiNet Plan;

(19) To arrange for the offering of continuing medical education courses that assist physicians, nurses and other clinicians in order to provide better care, consistent with the objectives of the SustiNet Plan, including training in culturally competent delivery of health care services;

(20) To appoint such advisory committees as may be deemed necessary for the authority to successfully implement the SustiNet Plan, further the objectives of the authority and secure necessary input from various experts and stakeholder groups;

(21) To establish and maintain an Internet web site that provides for timely posting of all public notices issued by the authority or the board and such other information as the authority or board deems relevant in educating the public about the SustiNet Plan; and

(22) To do all other acts and things necessary or convenient to carry out the purposes of and the powers expressly granted by this section.

(c) All state and municipal agencies, departments, boards, commissions and councils shall fully cooperate with the SustiNet Authority in carrying out the purposes enumerated in this section.

Sec. 4. (NEW) (*Effective July 1, 2009*) (a) The board shall develop the procedures and guidelines for the SustiNet Plan. Such procedures and guidelines shall be specific and ensure that the SustiNet Plan is established in accordance with the five following principles to guide health care reform as enumerated by the Institute of Medicine: (1) Health care coverage should be universal; (2) health care coverage should be continuous; (3) health care coverage should be affordable to individuals and families; (4) the health insurance strategy should be affordable and sustainable for society; and (5) health care coverage

should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.

(b) The board shall identify all funding sources that will be utilized to establish and administer the SustiNet Plan and such funding sources shall be included in the report prepared pursuant to section 22 of this act.

(c) The board shall adopt periodic action plans to achieve measurable objectives in areas that include, but are not limited to, effective management of chronic illness, preventive care, reducing racial and ethnic disparities as related to health care and health outcomes, and reducing the number of state residents without insurance. The board shall monitor the accomplishment of such objectives and modify action plans as necessary. The board's action plans and progress made with respect to achieving the objectives of such plans shall be included in the report prepared pursuant to section 22 of this act.

Sec. 5. (NEW) (*Effective July 1, 2009*) (a) For purposes of this section: (1) "Subscribing provider" means a licensed health care provider that: (A) Either is a participating provider in the SustiNet Plan or provides services in this state; and (B) enters into a binding agreement to pay a proportionate share of the cost of the goods and services described in this section, consistent with guidelines adopted by the board; and (2) "approved software" means electronic medical records software approved by the board, after receiving recommendations from the information technology committee, established pursuant to this section.

(b) Within available appropriations, the board shall: (1) Furnish approved software to subscribing providers and to participating providers, as the case may be, consistent with the capital acquisition, technical support, reduced-cost digitization of records, software updating and software transition procedures described in this section; and (2) develop and implement procedures to ensure that physicians,

nurses, hospitals and other health care providers gain access to hardware and approved software for interoperable electronic medical records and the establishment of electronic health records for SustiNet Plan members.

(c) The board shall establish an information technology committee that shall formulate a plan, which shall be subject to board approval prior to implementation, for developing, acquiring, financing, leasing or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers. Such plan shall include the development of a periodic payment system that allows subscribing providers to acquire approved software and hardware while receiving the services described in this section. Unless the board decides on an alternative financing method, capital acquisition costs shall be funded through issuance of a tax-exempt bond by the Connecticut Health and Educational Facilities Authority, established pursuant to section 10a-179 of the general statutes, that shall be repaid by subscribing providers as part of the periodic payment system.

(d) The information technology committee shall consult with health information technology specialists, physicians, nurses, hospitals and other health care providers, as deemed appropriate by the committee, to select software and hardware options that meet the needs of the full array of health care practices in the state. The committee shall negotiate with vendors to obtain reasonable prices for such software and hardware. Any electronic medical record package that the committee recommends for purchase shall include, to the maximum extent feasible: (1) A full set of functionalities for pertinent provider categories, including practice management, patient scheduling, claims submission, billing, issuance and tracking of laboratory orders and prescriptions; (2) automated patient reminders concerning upcoming appointments; (3) recommended preventive care services; (4) automated provision of test results to patients, when appropriate; (5) decision support, including a notice of recommended services not yet received by a patient; (6) notice of potentially duplicative tests and other services; (7) in the case of prescriptions, notice of potential

interactions with other drugs and past patient adverse reactions to similar medications; (8) notice of possible violation of patient wishes for end-of-life care; (9) notice of services provided inconsistently with care guidelines adopted pursuant to section 8 of this act, along with options that permit the convenient recording of reasons why such guidelines are not being followed; and (10) such additional functions as may be approved by the information technology committee.

(e) Approved software shall have the capacity to gather information pertinent to assessing health care outcomes, including activity limitations, self-reported health status and other quality of life indicators. Approved software shall also have the capacity to allow the board to track the accomplishment of clinical care objectives at all levels. The board shall ensure that SustiNet Plan providers who use approved software are able to electronically transmit to, and receive information from, all laboratories and pharmacies participating in the SustiNet Plan, without the need to construct interfaces, other than those constructed by the authority.

(f) On behalf of subscribing health care providers, the board shall negotiate with one or more vendors to provide reduced-cost, high-quality digitization of paper medical records for use with approved software. Such vendors shall be bonded, supervised and covered entities under the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, and in full compliance with other governing federal law.

(g) In the event that the producer of approved software ceases updating such software in a satisfactory fashion, terminates business operations or otherwise ceases satisfactory performance with respect to such approved software, the board shall ensure that subscribing providers are able to transition, free of additional charge, to an alternative vendor of approved software.

(h) The board shall, within available appropriations, hire or contract with health information technology professionals located in or serving residents of this state whose responsibility shall be to assist subscribing

health care providers make effective and efficient use of the health information technology provided pursuant to this section. Such professional assistance shall include help selecting approved software and hardware, training in and technical assistance with installation and operation, and providing pertinent information for revising and updating the applicable software and hardware.

(i) The information technology committee shall, within available appropriations, establish an integration system through which electronic medical records used by subscribing providers are integrated into a single electronic health record for each SustiNet Plan member, updated in real time whenever the member seeks or obtains care, and accessible to any participating or subscribing provider serving the member. Such electronic health record shall automatically update approved software, consistent with guidelines approved by the board. Such updates may include incorporating newly approved clinical care guidelines, software patches or other changes.

(j) All electronic medical records and electronic health records shall be developed and administered in a manner that is consistent with board-approved guidelines for safeguarding privacy and data security, consistent with state and federal law, including recommendations of the United States Government Accountability Office. Such guidelines shall include the remedies and sanctions that apply in the event of a provider's failure to comply with privacy or information security requirements. Remedies shall include notice to affected members and may include, in appropriate cases, termination of network privileges and denial or reduction of SustiNet Plan reimbursement. Remedies and sanctions provided by the board shall be in addition to those otherwise available under state or federal law.

(k) The board shall develop methods to eliminate or minimize transition costs for health care providers that, prior to July 1, 2009, implemented comprehensive systems of electronic medical records or electronic health records. Such methods may include technical assistance in transitioning to new software and development of

modules to help existing software connect to the integration system described in subsection (i) of this section.

(l) The board shall share with subscribing providers described in this subsection such providers' proportionate share of systemic cost savings that are specifically attributable to the implementation of electronic medical records and electronic health records. Such subscribing providers shall include those that, throughout the period of their subscription, have been participating providers in the SustiNet Plan and that, but for the savings shared pursuant to this subsection, would incur net financial losses during their first five years of using approved software. The amount of savings shared by the board with a provider shall be limited to the amount of net financial loss satisfactorily demonstrated by the provider. A provider whose losses resulted from the provider's failure to take reasonable advantage of available technical support and other services offered by the authority shall not share in the systemic cost savings.

(m) Electronic health records shall be structured to facilitate the provision of medical home functions pursuant to section 6 of this act. Electronic health records shall generate automatic notices to medical homes that: (1) Report when an enrolled member receives services outside the medical home; (2) describe member compliance or noncompliance with provider instructions, as relate to the filling of prescriptions, referral services, and recommended tests, screenings or other services; and (3) identify the expiration of refillable prescriptions.

(n) The authority shall ensure that each participating provider uses either approved software or other electronic medical record software that is interoperable with approved software and the electronic health record integration system described in subsection (i) of this section. The board shall develop and implement appropriate financial incentives for early subscriptions by participating providers, including discounted fees for providers who do not delay their subscriptions. No later than July 1, 2015, the board shall require as a condition of participation in the SustiNet Plan that each participating provider uses

either approved software or other electronic medical record software that is interoperable with approved software and the electronic health record integration system described in subsection (i) of this section. After July 1, 2015, the board may provide additional support to a provider that demonstrates to the satisfaction of the board that such provider would experience special hardship due to the implementation of electronic medical records and electronic health records requirements within the specified time frame. Such provider may qualify for additional support and an exemption from compliance with the time frame specified in this subsection, but only if such an exemption is necessary to ensure that members in the geographic locality served by the provider continue to receive excellent access to care.

(o) The authority shall coordinate the development and implementation of electronic medical records and electronic health records in concert with the Department of Public Health, the Office of Health Care Access, and other state agencies to ensure efficiency and compatibility. The authority shall determine appropriate financing options, including, but not limited to, financing through the Connecticut Health and Educational Facilities Authority established pursuant to section 10a-179 of the general statutes.

(p) To the extent that the authority procures hardware, software or services, such procurement shall take place through a competitive bidding process in accordance with applicable state laws.

Sec. 6. (NEW) (*Effective July 1, 2009*) (a) The board shall establish a medical home advisory committee that shall develop recommended internal procedures and proposed regulations governing the administration of patient-centered medical homes that provide health care services to SustiNet Plan members. The medical home advisory committee shall forward their recommended internal procedures and proposed regulations to the board in accordance with such time and format requirements as may be prescribed by the board. The medical home advisory committee shall be composed of physicians, nurses,

consumer representatives and other qualified individuals chosen by the board.

(b) Medical home functions shall be defined by the board on an ongoing basis that incorporates evolving research concerning the delivery of health care services. If limitations in provider infrastructure prevent all SustiNet Plan members from being enrolled in patient-centered medical homes, then enrollment in medical homes shall be implemented in phases with priority enrollment given to members for whom cost savings appear most likely, including, in appropriate cases, members with chronic health conditions.

(c) Subject to revision by the board, initial medical home functions shall include the following:

(1) Assisting members to safeguard and improve their own health by: (A) Advising members with chronic health conditions of methods to monitor and manage their own conditions; (B) working with members to set and accomplish goals related to exercise, nutrition, use of tobacco and other addictive substances, sleep, and other behaviors that directly affect such member's health; (C) implementing best practices to ensure that members understand medical instructions and are able to follow such directions; and (D) providing translation services and using culturally competent communication strategies in appropriate cases;

(2) Care coordination that includes: (A) Managing transitions between home and the hospital; (B) proactive monitoring to ensure that the member receives all recommended primary and preventive care services; (C) the provision of basic mental health care, including screening for depression, with referral relationships in place for those members who require additional assistance; (D) strategies to address stresses that arise in the workplace, home, school and the community, including coordination with and referrals to available employee assistance programs; (E) referrals, in appropriate cases, to nonmedical services such as housing and nutrition programs, domestic violence resources and other support groups; and (F) for a member with a

complex health condition that involves care from multiple providers, ensuring that such providers share information about the member, as appropriate, and pursue a single, integrated treatment plan; and

(3) Providing readily accessible, twenty-four-hour consultative services by telephone, secure electronic mail or quickly scheduled office appointments for purposes that include reducing the need for hospital emergency room visits.

(d) A licensed health care provider may serve as a medical home if such provider is authorized to provide all core medical home functions as prescribed by the board and operationally capable of providing such functions. A group practice or community health center serving as a medical home shall identify, for each member, a lead provider with primary responsibility for the member's care. In appropriate cases, as determined by the board, a specialist may serve as a medical home and a patient's medical home may temporarily be with a health care provider who is overseeing the patient's care for the duration of a temporary medical condition, including pregnancy.

(e) Each medical home provider shall be presented with a listing of all medical home functions, including patient education, care coordination and twenty-four-hour accessibility. If a provider does not wish to perform, within his or her office, certain functions outside core medical home functions, such provider shall, with assistance from the authority, make arrangements for other qualified entities or individuals to perform such functions, in a manner that integrates such functions into the medical home's clinical practice. Such qualified entities or individuals may be employed by or under contract with the authority, health care insurers or other individuals or entities and shall be certified by the authority based on factors that include the quality, safety and efficiency of the services provided. At the request of a core medical home provider, the authority shall make all necessary arrangements required for a qualified entity or individual to perform any medical home function not assumed by the core provider.

(f) The board, in consultation with the medical home advisory

committee, shall develop, monitor and enforce quality and safety standards for medical home functions that are not covered by existing professional standards, which may include care coordination and member education.

(g) The board may assist in the development of community-based resources to enhance medical home functions, including linguistically and culturally competent member education and care coordination. Such assistance may include hiring or contracting with necessary staff and arranging for low-interest loans that support the development of a community-based entities capable of fulfilling medical home functions.

(h) All of the medical home functions set forth in this section shall be reimbursable and covered by the SustiNet Plan. To the extent that such functions are generally not covered by commercial insurance, the authority shall set payment levels that cover the full cost of performing such functions. In setting such payment levels, the board may: (1) Utilize rate-setting procedures based on those used to set physician payment levels for Medicare; (2) establish monthly case management fees paid based on demonstrated performance of medical home functions; or (3) take other steps, as deemed necessary by the board, to make payments that cover the cost of performing each function.

(i) Specialty referrals shall include, under circumstances set forth in the board's guidelines, prior consultation between the specialist and the medical home to ascertain whether such referral is medically necessary. If such referral is medically necessary, the consultation shall identify any tests or other procedures that shall be conducted or arranged by the medical home, prior to the specialty visit, so as to promote economic efficiencies. The SustiNet Plan shall reimburse the medical home and the specialist for time spent in any such consultation.

Sec. 7. (NEW) (*Effective July 1, 2009*) (a) The board shall establish a health care provider committee that shall develop recommended clinical care and safety guidelines for use by participating health care providers. The committee shall choose from nationally and

internationally recognized guidelines for the provision of care, including guidelines for hospital safety and the inpatient and outpatient treatment of particular conditions. The committee shall continually assess the quality of evidence relevant to the costs, risks and benefits of treatments described in such guidelines. The health care provider committee shall forward their recommended clinical care and safety guidelines to the board in accordance with such time and format requirements as may be prescribed by the board. The health care provider committee shall include both health care consumers and health care providers.

(b) Health care providers participating in the SustiNet Plan shall receive confidential reports comparing their practice patterns with those of their peers. Such reports shall provide information about opportunities for appropriate continuing medical education.

(c) The board, in consultation with the health care provider committee, shall approve quality of care standards for the care of particular medical conditions. Such standards may reflect outcomes over the entire care cycle for each health care condition, adjusted for patient risk and general consistency of care with approved guidelines as well as other factors. Providers who meet or exceed quality of care standards for a particular medical condition shall be publicly recognized by the board in such manner as the board determines appropriate. Such recognition shall be effectively communicated to SustiNet Plan members, including those who have been diagnosed with the particular medical condition for which recognition has been extended. Such communication to members shall be in multiple forms and reflect consideration of diversity in primary language, general and health literacy levels, past health-information-seeking behaviors, and computer and Internet use among members.

(d) The board shall develop procedures that require hospitals and their medical staffs, physicians, nurse practitioners, and other participating health care providers to engage in periodic reviews of their quality of care. The purpose of such reviews shall be to develop

plans for quality improvement. Such reviews shall include the identification of potential problems manifesting as adverse events or events that could have resulted in negative patient outcomes. As appropriate, such reviews shall incorporate confidential consultation with peers and colleagues, opportunities for continuing medical education, and other interventions and supports to improve performance. To the maximum extent permissible, such reviews shall incorporate existing peer review mechanisms. Any review conducted in accordance with the provisions of this subsection shall be subject to the protections afforded by section 19a-17b of the general statutes.

(e) The board, in consultation with those hospitals serving SustiNet Plan members, shall develop hospital safety standards that shall be implemented in such hospitals. The board shall establish monitoring procedures and sanctions that ensure compliance by each participating hospital with such safety standards and may establish performance incentives to encourage hospitals to exceed such safety standards.

(f) The board may provide participating providers with information about prescription drugs, medical devices, and other goods and services used in the delivery of health care. Such information may address emerging trends that involve utilization of goods and services that, in judgment of the board, are less than optimally cost effective. The board may furnish participating providers with free samples of generic or other prescription drugs.

(g) The board may develop and implement procedures and incentives that encourage participating providers to furnish and SustiNet Plan members to obtain appropriate evidenced-based health care.

Sec. 8. (NEW) (*Effective July 1, 2009*) (a) The board shall establish a preventive health care committee that shall use evolving medical research to draft recommendations to improve health outcomes for members in areas involving nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances. The committee shall include providers, consumers and

other individuals chosen by the board. Such recommendations may be targeted to member populations where they are most likely to have a beneficial impact on the health of such members and may include behavioral components and financial incentives for participants. Such recommendations shall take into account existing preventive care programs administered by the state, including, but not limited to, state administered educational and awareness campaigns. Not later than July 1, 2010, and annually thereafter, the preventative health committee shall submit such recommendations, in accordance with section 11-4a of the general statutes, to the board and to the joint standing committees of the General Assembly having cognizance of matters relating to public health, appropriations and the budgets of state agencies and finance, revenue and bonding. Any recommendation of the committee that does not require legislative action may be presented to the board at any time.

(b) The SustiNet Plan shall provide coverage for community-based preventive care services and such services shall be required of all health insurance sold pursuant to the plan to individuals or employers. Community-based preventive care services are those services identified by the board as capable of being safely administered in community settings. Such services shall include, but not be limited to, immunizations, simple tests and health care screenings. Such services shall be provided by individuals or entities who satisfy board-approved standards for quality of care. Prior to furnishing a community-based preventive care service, a provider shall obtain information from a patient's electronic health record to verify that the service has not been provided in the past and that such services are not contraindicated for the patient. A provider shall promptly furnish relevant information about the service and the results of any test or screening to the patient's medical home or the patient's primary care provider if the patient does not have a medical home. Community-based preventive services may be provided at job sites, schools or other community locations consistent with the board's guidelines.

Sec. 9. (NEW) (*Effective July 1, 2009*) (a) The board shall develop

policies and procedures that ensure that, on and after July 1, 2011, SustiNet Plan membership is offered, as the form of employer-sponsored insurance furnished by the state, to all state employees and retirees and their dependents who qualify for health insurance coverage under state law, including those who would have qualified under state law as of January 1, 2009. The benefits, access to providers and out-of-pocket cost-sharing rules that apply to such members shall be consistent with all collective bargaining agreements that apply to such members. Only a SustiNet Plan member described in this subsection shall have his or her claims or other health care costs paid, in whole or in part, by payments for coverage of state employees and retirees described in this subsection. The coalition committee established pursuant to subsection (f) of section 5-278 of the general statutes shall retain jurisdiction over policy and practice matters that pertain exclusively to coverage for state employees and retirees. The coalition committee may overrule any decision of the board to the extent that such decision (1) would apply to state employees, retirees or their dependents; and (2) when compared to governing laws in effect on January 1, 2009, would reduce benefits, increase costs to enrollees, reduce access to care or lower the quality of care provided to individuals described in this subsection. The board shall take no action that impinges on a collective bargaining agreement applicable to state employees and retirees and such collective bargaining agreement shall remain in full force and effect unless amended.

(b) The board shall develop policies and procedures to ensure that HUSKY Plan Part A and Part B beneficiaries enroll in the SustiNet Plan. Such policies and procedures shall minimally provide that, to the extent permitted by federal law:

(1) Enrollment of HUSKY Plan beneficiaries begins on July 1, 2011, and be completed by June 30, 2013. A phased-in enrollment of HUSKY Plan beneficiaries may, at the discretion of the board, be implemented based on geographic regions.

(2) For HUSKY Plan providers enrolled in the SustiNet Plan,

provider reimbursement levels gradually increase above levels in effect on June 30, 2009, so that on and after July 1, 2011, per member per month costs, calculated separately for children and for adults, do not fall below the percentages of median costs for large group coverage in this state.

(3) Individuals who qualified or would have qualified for HUSKY Plan, Part A or Part B, Medicaid, or for medical assistance under the state administered general assistance program under state law as of January 1, 2009, not have a reduction in covered benefits or any increase in out-of-pocket cost-sharing or premiums.

(4) HUSKY Plan, Part A beneficiaries enrolled in SustiNet Plan not include any individuals who qualify for:

(A) Medicare;

(B) Supplemental Security Income; or

(C) Any category of Medicaid eligibility that is based on a disability, as such term is defined for purposes of eligibility under the Supplemental Security Income program, provided exemption from SustiNet Plan enrollment shall not apply to any individual who intermittently qualifies for Medicaid as medically needy based on incurring medical bills for services not involving long-term care.

(c) The board shall develop policies and procedures to ensure that on and after July 1, 2011, state residents who are not offered employer-sponsored insurance and who do not qualify for Medicare are permitted to enroll in the SustiNet Plan. Individuals with incomes above three hundred per cent of the federal poverty level shall receive a standard benefits package, unless such individuals choose to buy more comprehensive coverage, in which case such individuals, irrespective of income levels, shall pay the full increase in the premium amount needed to cover their proportionate share of the claims incurred by all individuals who purchase such comprehensive coverage. Individuals with income:

(1) Exceeding four hundred per cent of the federal poverty level shall not receive subsidies and can enroll in the SustiNet Plan at any time, beginning on July 1, 2011. Such individuals shall be subject to the same rules that apply in the individual market, pursuant to section 14 of this act, except that (A) preexisting conditions shall not be excluded, and (B) for individuals without continuous coverage, premiums shall be increased based on the length of applicable coverage gaps, consistent with standards developed by the board. For purposes of this subdivision, an individual who applies to enroll in the SustiNet Plan not later than sixty days after such enrollment is first offered shall be treated as having continuous coverage. The board shall ensure that outreach and public information strategies convey the importance of making a timely application for enrollment in the SustiNet Plan once it is initially offered.

(2) From three hundred one per cent of the federal poverty level to four hundred per cent of the federal poverty level, inclusive, shall receive premium subsidies and may enroll at any time beginning on July 1, 2011. Subsidies shall be provided as follows: (A) For individuals with incomes from three hundred one per cent of the federal poverty level to three hundred fifty per cent of the federal poverty level, inclusive, an amount sufficient to reduce premium costs to five per cent of household income for individuals of the applicable household size with incomes at three hundred per cent of the federal poverty level; and (B) for individuals with incomes from three hundred fifty-one per cent of the federal poverty level to four hundred per cent of the federal poverty level, inclusive, an amount sufficient to reduce premium costs to seven per cent of household income for individuals of the applicable household size with incomes at three hundred fifty per cent of the federal poverty level.

(3) At or below three hundred per cent of the federal poverty level may enroll in the HUSKY Plan, Part A or Part B, as applicable to the individual.

(d) The board shall develop policies and procedures to provide an

option for enrollment into the SustiNet Plan, rather than employer-sponsored insurance, for certain state residents who are offered employer-sponsored insurance. Such option shall be available on and after July 1, 2011. In order to be eligible for such enrollment option: (1) An individual shall be ineligible for Medicare; and (2) (A) the individual has family income at or below four hundred per cent of the federal poverty level and the employee's share of employer-sponsored insurance premiums shall exceed by not less than two per cent of household income, the premium amount the individual would pay for enrolling in SustiNet Plan; (B) an individual's diagnosed health conditions make it highly probable that he or she will incur out-of-pocket costs, which are not covered by employer-sponsored insurance, that exceed seven and one-half per cent of household income; or (C) the actuarial value of the individual's employer-sponsored insurance is less than eighty per cent of the median actuarial value of the health coverage offered by large employers in the Northeast states, as determined by the board. The board shall establish a simplified enrollment procedure for those individuals who demonstrate eligibility to enroll in the SustiNet Plan pursuant to this subsection. Notwithstanding any provision of the general statutes, an individual who enrolls in the SustiNet Plan pursuant to this subsection shall be counted as meeting any minimum participation requirement that a health insurance plan applies to an employer as a precondition of permitting the purchase of group health insurance coverage.

(e) For purposes of this subsection, "employer voucher" means the amount an employer would have paid for an individual employee's premiums if the individual employee had accepted the offer of employer-sponsored insurance. If an individual enrolls in the SustiNet Plan pursuant to subsection (d) of this section, the individual's employer shall pay to the authority an employer voucher, which shall be deposited in the SustiNet account established in section 15 of this act. An employer's payment of employer vouchers shall be limited as follows:

(1) The number of employer vouchers for a particular employer,

when added to the number of individuals who accept the employer's offer of coverage, shall not exceed the average percentage of employees and dependents, calculated separately, who accept employer-sponsored insurance offers in Northeast states for firms of the same general size and industry, as determined by the board; and

(2) The cost of employer vouchers, plus the amount the employer pays for employer-sponsored insurance premiums, shall not exceed what the employer would have paid for employer-sponsored health care coverage but for the implementation of sections 1 to 18, inclusive, 20 to 22, inclusive, and 24 to 26, inclusive. The board shall establish an administrative procedure to allow an employer to establish that the cost of employer vouchers, when added to the cost that the employer pays for employer-sponsored insurance premiums, exceeds the cost that the employer would have paid had the provisions of this section not been implemented. If the employer prevails in such administrative proceeding, the authority shall pay the employer's reasonable costs and attorneys' fees.

(f) For an individual enrollee who is required to pay premiums to the SustiNet Plan:

(1) The authority shall consult with the Department of Revenue Services to develop and implement effective and efficient methods of withholding premium payments from such individual enrollee's paycheck and depositing such payments directly into the SustiNet account established in accordance with the provisions of section 15 of this act. Such methods shall impose the lowest feasible administrative burden on employers; and

(2) The amount of any unpaid premiums during a calendar year shall be added to the individual's state income tax liability for the calendar year, with interest and penalties determined by treating the unpaid premium payments as state income tax obligations. Prior to the board informing the Department of Revenue Services that an individual enrollee did not pay required premiums to the SustiNet Plan, the board shall provide notice and an opportunity to be heard to

the individual enrollee so as to allow such individual enrollee the ability to challenge the board's determination that he or she did not pay required premiums to the SustiNet Plan or to allow such individual enrollee to arrange payment terms satisfactory to the board that do not involve a referral of the individual enrollee to the Department of Revenue Services. The board and the Department of Revenue Services shall develop procedures through which the additional income tax payment made under this subsection is forwarded to the SustiNet account established in accordance with the provisions of section 15 of this act.

Sec. 10. (NEW) (*Effective July 1, 2009*) (a) As used in this section "adverse selection" means purchase of SustiNet Plan coverage by employers with unusually high-cost employees and dependents under circumstances where premium payments do not fully cover the probable claims costs of the employer's enrollees.

(b) The authority is authorized to use new and existing channels of sale to employers, including public and private purchasing pools, agents and brokers. The authority is authorized to offer multi-year contracts to employers, offering predictable premiums. The board shall establish policies and procedures to ensure that employers can easily and conveniently purchase SustiNet Plan coverage for their workers and dependents. Such policies and procedures may include participation requirements, timing of enrollment, open enrollment, enrollment length and other subject matters as deemed appropriate by the board. The board shall develop such policies and procedures to prevent adverse selection and achieve other goals specified by the board.

(c) Beginning on July 1, 2011, small employers may purchase SustiNet Plan coverage. The authority shall vary premiums based on enrollees' characteristics as permitted for small employer carriers, as defined in subdivision (16) of section 38a-564 of the general statutes.

(d) Beginning on July 1, 2015, employers that are not small employers may purchase SustiNet Plan coverage. The authority may

vary the premiums charged to such employers to prevent adverse selection, taking into account past claims experience, changes in the characteristics of covered employees and dependents since the most recent time period covered by claims data, and other factors approved by the board.

(e) Employers purchasing coverage under this section shall be offered the standard benefits package. In addition, the board shall have the discretion to offer other benefits packages that, in the judgment of the board, provide enrollees with affordable access to essential health care. No such benefit package shall provide less comprehensive coverage than that described in the model benefits packages adopted pursuant to section 16 of this act.

(f) If the combination of employer premium payments and applicable reinsurance or stop loss coverage does not pay all employer enrollees' claims for a particular year, premiums in subsequent years shall be increased to cover the costs of claims incurred. Any such increases shall apply on a uniform, per enrollee basis to all employers that do not have multi-year contracts, unless the board finds a compelling reason to distribute such increases in a different fashion.

Sec. 11. (NEW) (*Effective July 1, 2009*) (a) As used in sections 11 and 12 of this act, "clearinghouse" means an independent information clearinghouse that is: (1) Established and overseen by the Office of the Healthcare Advocate; (2) operated by an independent research organization that contracts with the Office of the Healthcare Advocate; and (3) responsible for providing employers, individual purchasers of health coverage, and the general public with comprehensive information about the care covered by the SustiNet Plan and by private health plans.

(b) The clearinghouse shall develop specifications for data that show for each health plan, quality of care, outcomes for particular health conditions, access to care, utilization of services, adequacy of provider networks, patient satisfaction, rates of disenrollment, grievances and complaints, and any other factors the Office of the Healthcare

Advocate determines relevant to assessing health plan performance and value. In developing such specifications, the Office of the Healthcare Advocate shall consult with private insurers and with the board.

(c) The following entities shall provide data to the clearinghouse in a time and manner as prescribed by the Office of the Healthcare Advocate: (1) The SustiNet Plan; (2) health insurers, as a condition of licensure; and (3) any self-insured group plan that volunteers to provide data. Dissemination of any information provided by a self-insured group plan shall be limited and in conformity with a written agreement governing such dissemination as developed and approved by the group plan and the Office of the Healthcare Advocate.

(d) Except as provided for in subsection (c) of this section, the clearinghouse shall make public all information provided pursuant to subsection (b) of this section. The clearinghouse shall not disseminate any information that identifies individual patients or providers. The clearinghouse shall adjust outcomes based on patient risk levels, to the maximum extent possible. The clearinghouse shall make information available in multiple forms and languages, taking into account varying needs for the information and different methods of processing such information.

(e) The clearinghouse shall collect data based on each plan's provision of services over continuous twelve-month periods. Except as provided in subsection (c) of this section, the clearinghouse shall make public all information required by this section no later than August 1, 2012, with updated information provided each August first thereafter.

Sec. 12. (NEW) (*Effective July 1, 2009*) The intentional interference with fair and open competition between health insurers, which includes failure to report information accurately and completely to the clearinghouse as required by section 11 of this act, discouraging the offering of high-value private coverage in order to provide a competitive advantage to the SustiNet Plan, otherwise reducing the effectiveness or efficiency of one health plan in order to provide a

competitive advantage to another health plan, and intentional misrepresentations about covered benefits, costs, provider networks or plan performance, shall be subject to the provisions of section 1-89 of the general statutes. Fines, penalties and damages prescribed pursuant to said section shall be in addition to any other remedies that are available under state or federal law. For purposes of this section, the term "health insurer" shall include the SustiNet Plan, employer-sponsored health coverage and any individual or group insurance sold in the state.

Sec. 13. (NEW) (*Effective July 1, 2009*) (a) To the extent permitted by federal law, the Commissioner of Social Services shall take all steps necessary to ensure that on and after July 1, 2011, eligibility for enrollment in the HUSKY Plan, Part A includes all adults with incomes at or below one hundred eighty-five per cent of the federal poverty level, whether or not such adults are the custodial parents or caretaker relatives of minor children.

(b) The Commissioner of Social Services shall, to the extent permitted by federal law, take all steps necessary to ensure that on and after July 1, 2011, eligibility for enrollment in the HUSKY Plan, Part B includes adults with incomes from one hundred eighty-six per cent of the federal poverty level to three hundred per cent of the federal poverty level, inclusive. Such adults shall receive services and be responsible for cost-sharing requirements comparable to those imposed on households with children receiving HUSKY Plan, Part B benefits at the same income level, calculated as a percentage of the federal poverty level, taking into account the differential utilization of and need for services between adults and children. Adult enrollees in the HUSKY Plan, Part B program shall be charged a premium payment that is not less than twice the amount charged to the household of a child enrollee at the same income level, calculated as a percentage of the federal poverty level.

(c) On and after July 1, 2011, to the extent permitted by federal law, immigration status shall not be a factor in determining eligibility for

the HUSKY Plan, Part A or Part B, or for SustiNet premium subsidies. The SustiNet Authority and the Department of Social Services shall take all reasonable measures to maximize receipt of federal matching funds for the purposes of this subsection, provided state funds shall be used to the extent necessary to provide eligible individuals with health care insurance coverage in accordance with the provisions of this subsection.

Sec. 14. (NEW) (*Effective July 1, 2009*) Notwithstanding any provision of the general statutes, on and after July 1, 2011, individual health insurance policies may not be sold in the state unless they meet the following requirements: (1) Premiums for such policies may not vary based on individual characteristics except for the reasons and to the extent that such premiums are permitted to vary for the small group market; and (2) preexisting conditions may not be excluded when issuing such policies, except in circumstances when such exclusion would be permitted if the health insurance policy were for the small group market.

Sec. 15. (NEW) (*Effective July 1, 2009*) (a) There is established an account to be known as the "SustiNet account" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Investment earnings credited to the assets of the account shall become part of the assets of the account. The moneys in the account shall be used to defray the costs to the state of providing health care coverage under the SustiNet Plan, including related administrative costs. The SustiNet Authority shall be responsible for the disbursement of moneys from this account.

(b) The SustiNet Authority shall assist the Department of Social Services with the department's efforts to maximize the amount of federal matching funds used to help finance Medicaid, HUSKY Plan, Part A and Part B and SustiNet premium subsidies. The department's efforts shall include seeking any waivers under Titles XIX and XXI of the Social Security Act that are required for the effective

implementation of the SustiNet Plan, including a waiver, under Section 1115 of said act, to obtain the maximum amount of federal matching funds to provide coverage for adults under the programs described in this subsection.

(c) The authority and the Department of Social Services shall ensure, to the maximum extent permitted by federal law, that the cost of providing SustiNet services to individuals eligible for the HUSKY Plan, Parts A and B, and SustiNet premium subsidies, along with related administrative costs, are funded by deposits into the account established pursuant to subsection (a) of this section. Such deposits shall include any federal funds available to the state under Title XXI of the Social Security Act, as amended from time to time, that the state would otherwise not obtain, any federal matching funds provided under Titles XIX and XXI of said act that are available for services provided to SustiNet Plan members and any appropriations approved by the General Assembly for maintenance of effort payments as described in subsection (f) of this section.

(d) The authority shall determine the appropriate insurance premium contributions from individual enrollees and shall ensure that such contributions are deposited into the account established pursuant to subsection (a) of this section.

(e) (1) On and after January 1, 2012, any employer who does not offer group health insurance coverage to its employees and has a total payroll above the threshold amounts determined by the Department of Revenue Services pursuant to subdivision (2) of this subsection, shall be required to make annual shared responsibility payments as set forth in this subsection. The employees of such employer shall also be required to make annual shared responsibility payments as set forth in subdivision (3) of this subsection. Employer and employee shared responsibility payments shall be deposited in the account established pursuant to subsection (a) of this section. The Department of Revenue Services, in consultation with the board, shall develop polices and procedures to effectuate the collection of shared responsibility

payments that minimize the administrative burden on employers by collecting such payments through a modification to the existing payroll tax collection system.

(2) The Department of Revenue Services shall establish the threshold amounts that shall be based on the estimated average annual payroll for a private sector employer having ten employees. The Department of Revenue Services shall publish the threshold amount for a calendar year no later than October first of the preceding calendar year so that shared responsibility payments can be properly calculated and withheld by an employer.

(3) If an employer has total payroll above the threshold amount established pursuant to subdivision (2) of this subsection and such employer fails to offer health insurance coverage to its employees, such employer shall be responsible for making annual shared responsibility payments equal to the three per cent of such employer's payroll that is above the established threshold amount. The employees of such employer described shall collectively pay an amount equal to one per cent of the employer's payroll that is above the established threshold amount. The board, in consultation with the Department of Revenue Services, shall develop methods of collecting shared responsibility payments and allotting the employees' share equitably, based on earnings statements received from the applicable employer. For limited liability companies, S corporations and similar business entities, calculation of payroll amounts required to accomplish the purposes of this subsection shall equal the income that is subject to federal payroll taxation or federal self-employment taxation.

(f) For purposes of this subsection, "maintenance of effort payments" means total state health care expenditures that would have been incurred had the SustiNet Plan not been implemented. On or before December 31, 2009, and annually thereafter, the board shall report, in accordance with section 11-4a of the general statutes, to the Governor, the State Comptroller and the joint standing committees of the General Assembly having cognizance of matters relating to public health,

human services, labor and public employees, and appropriations and the budgets of state agencies on certified estimates of the maintenance of effort payments that are needed for the succeeding two fiscal years. Maintenance of effort payment estimates reported pursuant to this subsection shall take into account changes in average per capita health spending on a national level and the effects of state macroeconomic conditions on state-sponsored health care had the SustiNet Plan not been implemented. The board, in its discretion, may submit revised estimates, in accordance with the provisions of this subsection, if such revised estimates would have a significant impact on the administration of the SustiNet Plan.

Sec. 16. (NEW) (*Effective July 1, 2009*) (a) The Office of Healthcare Advocate shall develop and update the model benefit packages, based on evolving medical evidence and scientific literature, that make the greatest possible contribution to enrollee health for a premium cost typical of private, employer-sponsored insurance in the Northeast states. Not later than December 1, 2010, and biennially thereafter, the Office of Healthcare Advocate shall report, in accordance with the provisions of section 11-4a of the general statutes, to the board and to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, labor and public employees, appropriations and the budgets of state agencies and finance, revenue and bonding on the updated model benefit packages. The Office of Healthcare Advocate may contract with an independent, expert research organization for assistance in producing the report required by this subsection.

(b) After the promulgation of the model benefit packages, as provided in subsection (a) of this section, the board may modify the standard benefits package if the board determines that: (1) Such modification would yield better outcomes for an equivalent expenditure of funds; or (2) providing additional coverage or reduced cost-sharing for particular services as provided to particular enrollee populations may reduce net costs or provide sufficient improvements to health outcomes to warrant the resulting increase in net costs.

(c) The Office of the Healthcare Advocate shall recommend guidelines for establishing an incentive system that recognizes employers who provide employees with health insurance benefits that are equal to or more comprehensive than the model benefit packages. Such incentives may include public recognition of employers who offer such comprehensive benefits. Not later than December 1, 2010, the Office of the Healthcare Advocate shall report, in accordance with section 11-4a of the general statutes, on such guidelines and recommendations to the Governor, the State Comptroller and the joint standing committees of the General Assembly having cognizance of matters relating to public health, labor and public employees, and appropriations and the budgets of state agencies.

Sec. 17. (NEW) (*Effective July 1, 2009*) (a) The authority shall develop and implement public education and outreach campaigns to ensure that state residents are informed about the SustiNet Plan and are encouraged to enroll in the plan.

(b) This public education and outreach campaign shall utilize community-based organizations and shall include a focus on targeting populations that are underserved by the health care delivery system.

(c) The public education and outreach campaign shall be based on evidence of the cost and effectiveness of similar efforts in this state and elsewhere. Such campaign shall incorporate an ongoing evaluation of its effectiveness, with corresponding changes in strategy, as needed.

Sec. 18. (NEW) (*Effective July 1, 2009*) (a) The board, in collaboration with state and municipal agencies, shall, within available appropriations, develop and implement systematic methods to identify uninsured individuals in the state. Such methods shall include:

(1) Not later than July 1, 2011, the Department of Revenue Services shall, within available appropriations, modify state income tax forms to request that a taxpayer identify existing health coverage for each member of the taxpayer's household. The Department of Revenue

Services shall, within available appropriations, inform taxpayers that they may elect to restrict disclosure of income information contained in tax returns data, but that such election may impede the taxpayer's ability to obtain free or low-cost health insurance coverage. If a taxpayer indicates on a tax return that any member of the household is without health insurance coverage, such information shall be disclosed by the Department of Revenue Services to the board and the Department of Social Services to determine whether such taxpayer qualifies for free or low-cost health insurance coverage and to enroll such taxpayer into coverage. The Department of Revenue Services, the board and the Department of Social Services shall, within available appropriations, develop methods for the efficient, electronic transmission of information described in this subdivision to the board and the Department of Social Services for purposes of identifying uninsured individuals and determining eligibility for HUSKY Plan, Part A or Part B coverage, SustiNet premium subsidies and other sources of coverage, and enrolling such individuals promptly into health insurance coverage.

(2) Not later than July 1, 2011, the Labor Department shall, within available appropriations, modify application forms for initial and continuing claims for unemployment insurance to request information about health insurance status for the applicant and the applicant's dependents. Such modifications shall clearly advise the applicant that information concerning an individual identified as being without health insurance coverage shall be transmitted to the board and to the Department of Social Services for a determination of eligibility for free or low-cost health insurance coverage and for potential enrollment into such health insurance coverage. The Labor Department, the board and the Department of Social Services shall, within available appropriations, develop methods for the efficient, electronic transmission of information described in this subdivision to the board and the Department of Social Services for purposes of identifying uninsured individuals, determining their eligibility for HUSKY Plan, Part A or Part B coverage, SustiNet premium subsidies and other sources of coverage, and enrolling such individuals promptly into

health insurance coverage.

(3) Not later than July 1, 2011, the board, in collaboration with the Department of Social Services, shall develop a method by which hospitals, community health centers and other providers as determined by the board shall: (A) Identify uninsured individuals who seek health care, and (B) convey such information, via secure electronic mail transmission, to the board and said department to facilitate the potential enrollment of such individuals into health insurance coverage. The board shall develop procedures to ensure that, in such cases, the cost of care may be covered retroactively if an individual is enrolled in the SustiNet Plan.

(b) The board, in collaboration with the Department of Social Services, shall, within available appropriations, identify individuals who may be uninsured by matching databases that identify individuals with health insurance coverage, including data about private health insurance coverage made available pursuant to Section 6035 of the Deficit Reduction Act of 2005, against databases identifying state residents.

(c) On and after July 1, 2011, prior to enrolling any individual who appears to lack health insurance coverage in a state-administered health insurance plan, the identity of such individual shall be cross-matched against Department of Social Services databases to ensure that such individual lacks health insurance coverage. The board shall develop notice and hearing procedures, consistent with those used for beneficiaries under Title XIX of the Social Security Act, that allow an individual to contest a determination concerning the individual's health insurance coverage.

(d) On and after July 1, 2011, if an individual is determined to be uninsured, such individual may be enrolled in health insurance coverage in accordance with this subsection. Such individual shall receive notice that he or she is to be enrolled in health insurance coverage, with premiums charged based on income, not later than forty-five days after the date of receipt of such notice from the

authority, unless such individual provides proof of coverage, contests the determination that he or she lacks health insurance coverage as provided for in subsection (c) of this section, or affirmatively opts to remain uninsured. An individual enrolled in health insurance coverage under the provisions of this subsection shall receive premium discounts if such individual agrees to expedite his or her premium payments through voluntary wage withholding or other method of electronic funds transfer.

(1) Not later than July 1, 2011, an individual's initial income determination, for purposes of determining eligibility for HUSKY Plan, Part A and Part B and SustiNet premiums, shall be based on matches with all accessible, cost-effective sources of information concerning the individual's income, including, state income tax data, data available through the Enterprise Income Verification System, the National Directory of New Hires maintained by the Office of Child Support Enforcement within the United States Department of Health and Human Services, and information available from private vendors.

(2) The board shall develop notice and hearing procedures, consistent with the procedures used under Title XIX of the Social Security Act, that allow an individual to challenge an initial income determination and demonstrate lower income for purposes of obtaining a form of health insurance coverage that imposes fewer costs on the enrollee.

(3) Individuals who are enrolled in health insurance coverage and charged premiums for such coverage in accordance with the provisions of this subsection shall be provided notice of a final opportunity to opt out of such coverage. Such notice shall be included with the initial health insurance premium invoice, and shall include clear and conspicuous notice of the individual's final opportunity to opt out of health insurance coverage. Individuals who elect to opt out of health insurance coverage under the provisions of this subdivision shall do so not later than fifty days after the date on the initial premium invoice; or in the case of an individual who successfully

demonstrates that he or she did not receive the initial mailed premium invoice, not later than thirty days after the date of actual receipt of the initial health insurance premium invoice. An individual opting out of health insurance coverage pursuant to this subdivision shall be disenrolled from such coverage, and the authority shall waive any claim of past due premiums from such individual. If necessary to protect the individual's credit rating, the authority shall inform applicable credit agencies that no debt is owed from such individual.

(e) The board shall ensure that any individual, who is determined to be uninsured pursuant to subsections (b) and (f) of this section, shall be provided written information concerning the potential risks associated with the lack of health insurance coverage. The content of such written information shall be consistent with guidelines developed by the board. The board may also require such individuals to attend a presentation by the board on the potential risks associated with the lack of health insurance coverage. After being provided with such information, if the individual wishes to remain uninsured, the individual shall execute a signed writing, in such form as the board may prescribe, indicating that such individual, after being informed of the potential risks associated with the lack of health insurance coverage, has voluntarily elected to remain uninsured. An individual's decision to remain uninsured shall be effective for a period of time not to exceed one year from the date of executing the signed writing. Such decision to remain uninsured shall be renewed for subsequent one-year periods, using the informed consent procedures set forth in this subsection. Information required pursuant to this subsection shall be provided in multiple languages, as needed, to ensure that an individual fully comprehends the ramifications of electing to remain uninsured.

(f) An individual who lacks access to employer-sponsored insurance shall be enrolled in the SustiNet Plan. The board shall provide immediate post-enrollment outreach to such individual that includes the scope of coverage, premium obligations, if any, and the ability to voluntarily opt out of health insurance coverage, as set forth in

subsections (d) and (e) of this section. Information required pursuant to this subsection shall be provided in multiple languages, as needed, to ensure that an individual fully comprehends the benefits available under the SustiNet Plan and the ramifications of electing to remain uninsured.

(g) An individual with access to employer-sponsored insurance shall enroll in such employer-sponsored insurance, unless such individual elects to enroll in the SustiNet Plan pursuant to the provisions of subsection (d) of section 9 of this act or such individual chooses to remain uninsured consistent with the procedures set forth in subsections (d) and (e) of this section.

(h) The board shall develop and implement a plan that ensures that the enrollment procedures set forth in this section begin on July 1, 2011, and shall be phased in to operate state-wide by July 1, 2014. The board shall develop an appropriate phase-in strategy, that may be based on geography and that allows for strategy modification on an as needed basis.

Sec. 19. Section 17b-297b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) To the extent permitted by federal law, the Commissioners of Social Services and Education, in consultation with the board of directors of the SustiNet Authority established pursuant to section 2 of this act, shall jointly establish procedures for the sharing of information contained in applications for free and reduced price meals under the National School Lunch Program for the purpose of determining whether children participating in said program are eligible for coverage under the SustiNet Plan or the HUSKY Plan, Part A and Part B. The Commissioner of Social Services shall take all actions necessary to ensure that children identified as eligible for **[**either**]** SustiNet Plan, or the HUSKY Plan, Part A or Part B, are enrolled in the appropriate plan.

(b) The Commissioner of Education shall establish procedures

whereby an individual may apply for the SustiNet Plan or the HUSKY Plan, Part A or Part B, at the same time such individual applies for the National School Lunch Program.

Sec. 20. (NEW) (*Effective July 1, 2011*) (a) The board, in collaboration with the Department of Social Services, shall ensure that the application and information retention process for the HUSKY Plan, Part A and Part B and for SustiNet premium subsidies is convenient and consumer-friendly. Such application and information retention process shall safeguard individual privacy and be designed and administered in a manner that is consistent with obtaining federal matching funds for the benefit of those who qualify for health insurance coverage under the provisions of this section and sections 1 to 18, inclusive, and section 21 of this act.

(b) Individual assets shall not be a factor in determining eligibility for HUSKY Plan, Part A or Part B or SustiNet premium subsidies.

(c) To the extent permitted by federal law, eligibility for HUSKY Plan, Part A and Part B and SustiNet premium subsidies shall be certified for twelve-month periods, based on information available at the time of application. Changes in household circumstances during that year shall not affect eligibility, except that an enrollee may qualify for less costly coverage or coverage that includes additional benefits if such enrollee satisfactorily demonstrates reduced income, lost health insurance coverage or other relevant changes in household circumstances since the time of application.

(d) The Department of Social Services, when determining the proportion of individuals who are enrolled in the HUSKY Plan, Part A and Part B or who receive SustiNet premium subsidies and who are eligible for federal matching funds based on immigration status, shall, to the extent permitted by federal law, (1) claim matching funds based on statistically valid caseload samples rather than individual applications that provide evidence of their immigration status; and (2) document applicant citizenship and immigration status whenever possible through data matches with federal authorities, rather than

requiring applicants to provide copies of relevant documents.

(e) The Department of Social Services, when redetermining eligibility for the HUSKY Plan, Part A and Part B, and for SustiNet premium subsidies, shall minimize procedural terminations of benefits through the use of administrative renewals, ex parte renewals and telephonic renewals.

Sec. 21. (NEW) (*Effective July 1, 2009*) (a) The board shall retain discretion to revise the policies and practices set forth in sections 3 to 8, inclusive, of this act, concerning the operation and administration of the health care delivery system serving SustiNet members. Policy and practice revisions shall be based on best practices and emergent evidence concerning improvements to the health care delivery system.

(b) The board shall conduct an ongoing examination of the use of electronic health records and other data to identify outstanding practices that would improve quality and value of care provided to SustiNet Plan members. Such examination shall include analysis of the factors that lead to outstanding performance by particular providers and incorporating such factors into the SustiNet Plan. The board shall also use electronic health records to evaluate the comparative effectiveness of alternative treatments, weighing both the benefits and risks of such alternative treatments. The board may collaborate with other in-state and out-of-state entities undertaking similar efforts.

(c) The board shall regularly evaluate member success in obtaining health insurance coverage, accessing care and experiencing positive health outcomes. The board shall revise policies and practices when necessary to improve care for members as a whole or for vulnerable subsets of the entire SustiNet Plan membership. Subjects that the board shall regularly evaluate shall include, but not be limited to: (1) The application and enrollment process; (2) access to, utilization of, and quality of healthcare; (3) overall health status; and (4) the effectiveness of any policies and practice that are revised pursuant to this subsection or subsection (a) of this section.

(d) If, in the judgment of the board, the SustiNet Plan is causing a significant shift of costs from employers to consumers or to the public sector, the board, in consultation with the Department of Social Services, may modify SustiNet Plan coverage, including eligibility for SustiNet premium subsidies and adult coverage offered through the HUSKY Plan, Part B, to remedy such cost shift, except that no eligibility or other restriction may be imposed on individuals who would have qualified for state-sponsored health insurance coverage under state law that was in effect on January 1, 2009.

(e) If, in the judgment of the board, the SustiNet Plan is experiencing significant harm as the result of adverse selection by individuals or employers, the board may revise the terms and conditions of enrollment into the SustiNet Plan.

(f) If, in the judgment of the board, significant numbers of uninsured residents are being deterred from enrolling into the SustiNet Plan by the cost of premiums, the board may increase premium subsidies to reduce such costs.

(g) If, in the judgment of the board, significant numbers of people without access to SustiNet Plan coverage are receiving employer-sponsored insurance that does not provide affordable access to the full range of necessary health care, the board may revise the circumstances under which individuals offered employer-sponsored insurance may enroll in the SustiNet Plan.

(h) Prior to the board implementing a policy revision as set forth in this section, the board shall conduct a public hearing to obtain input on the proposed policy revision. The board shall ensure that not less than thirty days notice of such public hearing is provided to the public, by publication in not less than three newspapers having a substantial circulation in the state, to the board's appointing authorities, by publication on the authority's web site, and to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, labor and public employees, appropriations and the budgets of state agencies and finance, revenue

and bonding.

(i) The board shall monitor the federal law, regulations and policy relevant to the implementation of sections 1 to 18, inclusive, 20 to 22, inclusive, and 24 to 26, inclusive, of this act. In order to optimally position the state to benefit from changes to federal law, regulation and policy, the board: (1) May, to the extent permitted by this act and other applicable state and federal law, modify board regulations, policies and guidelines to conform to changes in federal law, and (2) shall promptly make recommendations to the General Assembly for any necessary or advisable changes to this act or other provisions of state law.

Sec. 22. (NEW) (*Effective July 1, 2009*) (a) On or before December 1, 2010, and annually thereafter, the authority shall report, in accordance with the provisions of section 11-4a of the general statutes, to the appointing authorities of the board of directors and to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, labor and public employees, appropriations and the budgets of state agencies and finance, revenue and bonding on the status of health care in the state. Such report shall include information on the status of health care in this state in general, as well as, the design and implementation of the SustiNet Plan. The report shall include recommendations for legislative changes that should be made concerning the administration of the SustiNet Plan.

(b) Each report filed on or after December 1, 2011, shall include:

(1) General trends in coverage, health outcomes, quality and access for SustiNet Plan members;

(2) Health care provider workforce issues;

(3) The extent to which employer-sponsored health insurance coverage provides affordable access to necessary health care for employees and their dependents, including those with low incomes

and health problems, along with policy options for addressing any problems identified; and

(4) Whether provider networks are sufficient to furnish all SustiNet Plan members with excellent access to care and, to the extent that any members lack such access, proposals that remedy this deficiency.

(c) Each report filed on or after December 1, 2012, shall include:

(1) Recommendations as to whether SustiNet Plan coverage should be extended to serve Medicare enrollees who are not state retirees, and if so, the extent of such coverage;

(2) A recommendation as to whether SustiNet Plan coverage should be extended to serve Medicaid enrollees who are not enrolled in the SustiNet Plan due to age or disability, and if so, the extent and nature of such coverage;

(3) Whether implementation of the SustiNet Plan has caused a shift of costs from employers to taxpayers, and if so, proposals to remedy such cost shift; and

(4) Whether additional changes to individual market regulation are needed.

(d) Each report filed on or after December 1, 2012, shall indicate whether shared responsibility payments should be modified to reflect an employer's ability to pay based on size, wage level, industry and other factors.

(e) Each report filed on or after December 1, 2013, shall indicate whether deficits or excesses in the physical infrastructure of the health care system are increasing health care costs without yielding corresponding gains in patient health outcomes, and if so, proposals to remedy such deficits or excesses.

(f) Each report filed on or after December 1, 2014, shall address the effectiveness of the state's voluntary system of providing health care

coverage to all state residents, including those who are young and healthy, and the advantages and disadvantages of changing state law to mandate each resident to obtain coverage.

Sec. 23. Subdivision (1) of section 1-120 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(1) "Quasi-public agency" means the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Health and Educational Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Capital City Economic Development Authority, **[**and**]** Connecticut Lottery Corporation and the SustiNet Authority.

Sec. 24. (NEW) (*Effective July 1, 2009*) The state shall protect, save harmless and indemnify the SustiNet Authority and its directors, officers, contractors and employees from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand, suit or judgment based upon any alleged act or omission of the authority or any such director, officer, contractor or employee in connection with, or any other legal challenge to, the SustiNet Plan, as defined section 1 of this act, provided any such director, officer, contractor or employee is found to have been acting in the discharge of such director, officer, contractor or employee's duties or within the scope of such director, officer, contractor or employee's employment and any such act or omission is found not to have been wanton, reckless, wilful or malicious.

Sec. 25. (NEW) (*Effective July 1, 2009*) Notwithstanding any other provision of state law, no state court shall have jurisdiction to hear a claim that any provision of sections 1 to 18, inclusive, 20 to 22, inclusive, 24 to 26, inclusive, of this act, violates the Employee Retirement Income Security Act of 1974.

Sec. 26. (NEW) (*Effective July 1, 2009*) If any of the provisions of

sections 1 to 18, inclusive, 20 to 22, inclusive, 24 to 25, inclusive, of this act, or the applicability or enforceability thereof is held invalid by any court of competent jurisdiction, the remainder of the provisions of said sections shall not be affected thereby.

Sec. 27. (*Effective from passage*) (a) There is established a task force to study childhood and adult obesity. The task force shall examine evidence-based strategies for preventing and reducing obesity in children and adults and develop a comprehensive plan that will effectuate a reduction in obesity among children and adults.

(b) The task force shall consist of the following members:

(1) One appointed by the speaker of the House of Representatives, who shall represent a consumer group with expertise in childhood and adult obesity;

(2) One appointed by the president pro tempore of the Senate, who shall be an academic expert in childhood and adult obesity;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the business community with expertise in childhood and adult obesity;

(4) One appointed by the majority leader of the Senate, who shall be a health care practitioner with expertise in childhood and adult obesity;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the business community with expertise in childhood and adult obesity;

(6) One appointed by the minority leader of the Senate, who shall be a health care practitioner with expertise in childhood and adult obesity;

(7) One appointed by the Governor who shall be an academic expert in childhood and adult obesity; and

(8) The Commissioners of Public Health, Social Services and Economic and Community Development and a representative of the SustiNet board of directors shall be ex-officio, nonvoting members of the task force.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The members of the task force appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall serve as the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held no later than thirty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(g) Not later than July 1, 2010, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2011, whichever is later.

Sec. 28. (*Effective from passage*) (a) There is established a task force to study tobacco use by children and adults. The task force shall examine evidence-based strategies for preventing and reducing tobacco use by children and adults, and then develop a comprehensive plan that will effectuate a reduction in tobacco use by children and adults.

(b) The task force shall consist of the following members:

(1) One appointed by the speaker of the House of Representatives, who shall represent a consumer group with expertise in tobacco use by children and adults;

(2) One appointed by the president pro tempore of the Senate, who shall be an academic expert in tobacco use by children and adults;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the business community with expertise in tobacco use by children and adults;

(4) One appointed by the majority leader of the Senate, who shall be a health care practitioner with expertise in tobacco use by children and adults;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the business community with expertise in tobacco use by children and adults;

(6) One appointed by the minority leader of the Senate, who shall be a health care practitioner with expertise in tobacco use by children and adults;

(7) One appointed by the Governor who shall be an academic expert in tobacco use by children and adults; and

(8) The Commissioners of Public Health, Social Services and Economic and Community Development and a representative of the SustiNet board of directors shall be ex-officio, nonvoting members of the task force.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The members of the task force appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall serve as the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held no later than thirty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(g) Not later than July 1, 2010, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2011, whichever is later.

Sec. 29. (*Effective from passage*) (a) There is established a task force to study the state's health care workforce. The task force shall develop a comprehensive plan for preventing and remedying state-wide, regional and local shortage of necessary medical personnel.

(b) The task force shall consist of the following members:

(1) One appointed by the speaker of the House of Representatives, who shall represent a consumer group with expertise in health care;

(2) One appointed by the president pro tempore of the Senate, who shall be an academic expert on the health care workforce;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the business community with expertise in health care;

(4) One appointed by the majority leader of the Senate, who shall be a health care practitioner;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the business community with expertise in health care;

(6) One appointed by the minority leader of the Senate, who shall be a health care practitioner;

(7) One appointed by the Governor who shall be an academic expert in health care; and

(8) The Commissioners of Public Health, Social Services and Economic and Community Development, the president of The University of Connecticut, the chancellor of the Connecticut State University System, the chancellor of the Regional Community-Technical Colleges, and a representative of the SustiNet board of directors shall be ex-officio, nonvoting members of the task force.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The members of the task force appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall serve as the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held no later than thirty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(g) Not later than July 1, 2010, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public

health, human services and appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2011, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	New section
Sec. 2	*July 1, 2009*	New section
Sec. 3	*July 1, 2009*	New section
Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	New section
Sec. 6	*July 1, 2009*	New section
Sec. 7	*July 1, 2009*	New section
Sec. 8	*July 1, 2009*	New section
Sec. 9	*July 1, 2009*	New section
Sec. 10	*July 1, 2009*	New section
Sec. 11	*July 1, 2009*	New section
Sec. 12	*July 1, 2009*	New section
Sec. 13	*July 1, 2009*	New section
Sec. 14	*July 1, 2009*	New section
Sec. 15	*July 1, 2009*	New section
Sec. 16	*July 1, 2009*	New section
Sec. 17	*July 1, 2009*	New section
Sec. 18	*July 1, 2009*	New section
Sec. 19	*July 1, 2011*	17b-297b
Sec. 20	*July 1, 2011*	New section
Sec. 21	*July 1, 2009*	New section
Sec. 22	*July 1, 2009*	New section
Sec. 23	*July 1, 2009*	1-120(1)
Sec. 24	*July 1, 2009*	New section
Sec. 25	*July 1, 2009*	New section
Sec. 26	*July 1, 2009*	New section
Sec. 27	*from passage*	New section
Sec. 28	*from passage*	New section
Sec. 29	*from passage*	New section

PH *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: See Below

Municipal Impact: See Below

Explanation

This bill establishes the SustiNet Plan to extend health insurance coverage. There are a variety of major impacts, as detailed below.

SustiNet Authority

The bill establishes a quasi-public entity called "SustiNet" to be operated by a nine member board of directors who have the authority to hire staff to develop and implement the SustiNet Plan, a self-insured health care delivery plan to a variety of enrollees. Board members are not compensated, but can be reimbursed for expenses related to carrying-out their duties. Expenses would also be incurred for the hiring of staff necessary to carry-out the responsibilities of the SustiNet Authority.

The board must adopt procedures governing how it: (1) adopts an annual budget and operational plan; (2) hires, dismisses, promotes, and compensates employees; (3) contracts for professional services; (4) establishes a system for electronic health records for members and providers; (5) awards loans and grants; and (6) contracts with insurers or other entities for administrative purposes, such as claims processing, risk management, utilization review, and credentialing of providers. Implementation of each of these items will result in significant expenditures by the quasi-public authority. The effective date for creation of this entity is July 1, 2009, thus the funding requirements would be necessary in FY 10.

While the bill contains numerous references to carry-out its duties "within available appropriations", none have been provided for in this bill or in the Appropriation Committee's proposed FY 10–FY 11 biennial budget, sHB 6365. The board is charged with indentifying all funding sources that will be utilized to establish and administer the SustiNet plan. The board is required to offer, by July 1, 2011, the SustiNet health plan to those eligible within the bill. At that time the Authority may receive revenue from administrative charges applied to its insurance product. Administrative savings may accrue to certain state agencies that are currently carrying out some of the authority's health care functions.

The bill establishes a separate, nonlapsing General Fund account (the "SustiNet Account") for claims payment and related administrative costs. The bill charges the Authority with depositing all funds received into the account and allows the Authority to use the account to defray the costs to the state of providing health care coverage under the SustiNet Plan. The earliest funds could be received would be July 1, 2011, assuming the Authority was ready to deliver its SustiNet Plan to potential members.

While no similar entity currently exists in Connecticut state government, the Office of Fiscal Analysis has examined the administrative operating costs associated with the Massachusetts Commonwealth Health Insurance Connector which became operational in 2007. While the two entities different in certain aspects of their operations, they are similar in scope.

The Massachusetts Commonwealth Health Insurance Connector currently employs 43 staff members and provides health care coverage to 165,000 members. The Connector has an estimated administrative operating budget for FY 09 of $35.1 million with total health premium coverage of $782 million. Direct staff salaries and benefits are estimated to be $6.2 million for FY 09. Other administrative costs of $28.9 million are for such items as communications, customer service, premium billing and consulting services. The Connector does not

provide any self-insured health plans rather contracts with existing health plan providers for its members. The Connector does provide subsidies for certain members based on income. The Connector was provided with an initial $25 million appropriation from the Massachusetts legislature prior to start-up.

The SustiNet Authority would be responsible for providing a self insured health care plan, by July 1, 2011, for the HUSKY population which is estimated at 391,000 members, with a premium equivalent cost of $1.2 billion. In addition, SustiNet may be the sole provider of insurance to state employees and retirees if a collective bargaining agreement is negotiated with the State Employee Bargaining Agent Coalition prior to July 1, 2011. Currently, the state provides health care coverage for 183,000 members at a cost of $870 million. There would be potential administrative savings in the agencies currently administering both the HUSKY and state employee health care.

State Employee & Retiree Health Plan

This bill may require conversion of the state health plans to self-funded SustiNet Plan coverage beginning on or after July 1, 2011. For this change to occur, consent would be required from the State Employees' Bargaining Agent Coalition (SEBAC) to amend a collectively bargained agreement in effect until 2017. As a self-insured health care delivery plan, the SustiNet Plan would pay directly for participant claims on an incurred-and-reported basis. When the state health plans move from fully-insured plans to a self-insured mechanism, the premiums paid to private contracted health insurers cease and claims begin to be paid directly from a self-insured pool. In the event that SEBAC decides not to offer only one plan through SustiNet, there is no requirement that the remaining state employee health care coverage be moved to a self-insured plan. Therefore, the savings accrued from a delay in claims payments would be diminished.

There is a potential one-time savings due to the typical 30 to 60 day lag in the payment of provider health claims after services are

rendered. Currently, the Comptroller pays approximately $70 million in fully-insured health care premiums each month for active and retired state employees. One-time savings will result from the lag in claims incurred but not yet reported to the new self-insured in the first two months of the transition. Assuming that half of the claims incurred are paid in the first two months, the General Fund would obtain a one-time savings of $70 million in FY 10.

The current fully-insured contract for state employee and retiree health insurance includes a rate cap of approximately 10% in FY 10 and 12.5% in FY 11 across all health care plans to hold down costs in the biennium. The state's actual premium rates in FY 10 and FY 11 will be determined from the past year's average monthly claims per employee. For example, if the average FY 09 trend increase is 5%, then premiums would similarly increase by 5% in FY 10. If instead the average FY 09 claims were 13%, premiums would only increase 10% due to the rate cap. Other administrative charges would only increase according to the CPI index. By going self-insured, these rate caps become obsolete and the state assumes direct financial responsibility for all costs of enrollees' medical claims.

The first quarter of FY 09 had an average claims loss ratio of 97 percent (versus an average rate of 88% last year).[1] As a result, savings over the FY 10 - FY 11 period could be minimal or non-existent if loss ratios remain at current levels or continue to increase. Based on information obtained from the Comptroller's Office, switching to a self-insured plan could result in FY 10 rates that are 5.9% higher than the maximum rate under the existing fully-insured contract, which equates to an additional $69 million in health costs for the state plan.

Section 3, subparagraph 15 provides the SustiNet Authority with the opportunity to enter into interagency agreements for performance of SustiNet duties that may be implemented more efficiently by an

[1] Health insurance costs are attributed primarily to claims experience. These "loss costs" for state employees and retirees are generally in the range of 80 percent of the

existing agency. To the extent that the SustiNet Authority continues to utilize the Office of the State Comptroller in executing its statutory responsibility to procure health care benefits for state employees and retirees, there will be no administrative cost savings to the State or to the plan itself.

To the extent that the SustiNet Plan can provide ongoing health coverage at a lower cost than private health plans, additional annual savings could be achieved. While the bill does not require SustiNet to provide for reserves to cover claims, it is a common practice to establish a rate stabilization reserve consisting of approximately 2 months worth of anticipated claims.

Public Assistance Programs

The bill requires all HUSKY A and B clients to be enrolled in the SustiNet plan by June 30, 2013. Additionally, it specifies that all uninsured individuals in the state with incomes under 300% of the Federal Poverty Level (FPL) are eligible to enroll in either HUSKY A or B.

The bill specifies that there be no reduction in HUSKY or State Administered General Assistance (SAGA) benefits or any increases in cost sharing or premiums as compared to the current benefit packages. The bill also requires that HUSKY provider reimbursement rates be gradually increased to the median cost for large group coverage.

These programmatic expansions and rate increases would increase quantifiable gross state costs by at least $1.75 billion annually when fully implemented. This figure assumes that current levels of those with insurance are maintained. To the extent that employers or individuals currently insured opt to drop coverage to take advantage of the new eligibility levels, this cost could increase.

- **Reimbursement Rates**

premium paid to health plans, but can vary from year to year based upon the health experience of the pool of covered lives.

Given the thousands of individual rates paid under the HUSKY programs, exact comparisons between current HUSKY rates and private coverage rates are not possible. The Office of Health Care Access' (OHCA) 2007 Annual Report on the Financial Status of Connecticut's Hospitals indicates that, on average, Medicaid pays 67% of actual costs, while private insurance pays 118% of actual costs. This would indicate that a 75% rate increase would be necessary to make Medicaid equivalent to private insurance for hospitals. As reliable data does not exist for other rate comparisons, the Office of Fiscal Analysis uses the rate hospital comparison as a proxy.

It is assumed that the required rate increases would apply to the services currently covered by the Department of Social Services (DSS) funded managed care organizations, as well as the dental and behavioral health carve outs. DSS pharmaceutical purchasing program is assumed to be outside this requirement. Based on an FY 12 current service projection for the applicable portions of the HUSKY programs of nearly $1.2 billion, a 75% rate increase would result in an additional annualized cost of $900 million.

- **Enrollment Increases**

The bill allows anyone who is uninsured with an income below 300% FPL to enroll in the HUSKY programs. According to OHCA's Health Insurance Coverage Databook, it is estimated that in 2006 (the latest year for which data is available) there were 148,400 uninsured individuals below 300% FPL. Based on the reimbursement increases noted above, fully enrolling these uninsured individuals in HUSKY would cost approximately $800 million annually.

Since the time of the OHCA survey, the state has implemented the Charter Oak health insurance program. Therefore, some of the uninsured noted above are likely to already be covered in Charter Oak. Assuming that Charter Oak is subsumed by SustiNet, the $900 million cost noted above would be reduced by the estimated $40 million that the state is expected to pay for Charter Oak in FY12, resulting in a net cost of $760 million.

This estimate would also assume the enrollment of the current SAGA population in HUSKY. Currently, SAGA has a different benefit structure and payment mechanism than the HUSKY program. Therefore, enrolling SAGA clients in HUSKY would necessitate converting these aspects of SAGA to the HUSKY structure. The exact cost of such a conversion is not known. However, assuming that these changes add 40% to the FY12 current service cost for SAGA, an additional $90 million annual cost would result.

The above noted costs for enrollment increases assume that the enhanced rates paid for the HUSKY programs will be applied to the expansions. However, those rates are based on coverage mostly for women and children, who are a relatively low cost insurance group. Expanding this risk pool to include SAGA and other uninsured individuals may result in future actuarial increases in HUSKY rates.

The bill further states that immigration status shall not be a factor in determining eligibility for SustiNet or the HUSKY programs. Should this be read to allow illegal immigrants to enroll in these programs, additional costs will result. An estimated 39,000 illegal immigrants reside in Connecticut. It is not known how many are: 1) uninsured; 2) have incomes that would makes them eligible for HUSKY; or 3) are already counted in the above estimates of uninsured. For purposes of illustration, should this provision lead to a quarter of the 39,000 enrolling in the HUSKY programs, an additional cost of $50 million annually would result.

- **Federal Reimbursement**

Generally, the state receives federal reimbursement for the HUSKY A (50%) and the HUSKY B (65%) programs. Additionally, the state receives a 50% match for hospital inpatient and outpatient costs under the SAGA program through the federal disproportionate share hospital program.

The bill directs DSS to take any steps necessary to secure federal reimbursement for the eligibility increases mandated by the bill. As

the increases are outside the normal eligibility standards allowed by the federal government, there is no guarantee that federal reimbursement will be secured.

Additionally, the substantial rate increases required by the bill may not be fully eligible for federal reimbursement. The federal government will not reimburse certain rates that exceed the upper payment limit. It is not known the extent to which this may reduce the potential federal reimbursement.

- **Subsidized SustiNet**

The bill requires SustiNet to subsidize benefits for certain individuals between 300% FPL and 400% FPL. These subsidies would allow individuals to pay for benefits on a sliding fee scale, depending on income. According to the US Census Bureau, there are approximately 174,000 households, with 435,000 individuals, within this income band. The cost of this subsidy cannot be known, as the cost of the SustiNet standard benefit has not yet been determined and it is not known how many potentially eligible individuals would partake in the benefit. However, given the total number of individuals in this income bracket, any such subsidy is likely to have a significant cost.

Other State Agency Impact

The bill has further requirements that may lead to additional administrative costs for the Departments of Public Health, Revenue Services, Labor, Insurance, and the Office of Health Care Access.

Municipal Impact

There are approximately 110,000 municipal employees (including boards of education). It is possible that certain municipalities (particularly smaller towns and non-state public groups), small non-profit organizations and small employers will achieve savings from SustiNet's large-group purchasing power, pooled risk and administrative economies of scale. In order for these groups to

determine if they can achieve a savings under the proposed plan, employers must examine not only the rates and plan design but also 2 to 3 years of its utilization data.

Sources: *Department of Social Services Caseload Information*
Office of the State Comptroller
United States Census Bureau
U.S. Citizenship and Immigrations Services Reports
Various Reports on Massachusetts Health Reform
Office of Health Care Access Reports and Publications

OLR Bill Analysis

sHB 6600

AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

SUMMARY:

This bill establishes the "SustiNet Plan," a new state health care program intended to extend insurance coverage to the state's uninsured. Among its many provisions, the bill:

1. creates a large insurance pool that includes recipients of Medicaid and HUSKY, state employees and retirees, families without health insurance from an employer, and individuals having difficulty affording high-cost insurance on the job;

2. digitizes medical records linked to a central database that physicians and other providers must use as a condition of participation in SustiNet;

3. creates "medical homes" that offer patients round-the-clock central coordination of their health care as well as guidance in managing it;

4. relies on periodic quality review of providers and evidence-based medicine; and

5. provides for public health campaigns in support of such measures as health screenings and immunizations.

The bill establishes the "SustiNet" Authority operated by a nine member board of directors composed of health care consumers, employers, health care experts, providers, labor, and business. The authority's purpose is to develop and implement the SustiNet Plan, a self-insured health care delivery plan operated by a public-private

partnership designed to ensure that plan enrollees receive high quality health care coverage without unnecessary costs.

The bill also creates task forces addressing obesity, tobacco usage, and the health care workforce.

EFFECTIVE DATE: July 1, 2009, except that the sections on indentifying uninsured children (§ 19) and eligibility determination (§ 20) take effect July 1, 2011, and the three task forces established (§§ 27-29) take effect upon passage.

§ 1 — DEFINITIONS

The bill defines the " SustiNetPlan" as a self-insured health care delivery plan, administered by the SustiNet Authority (see § 2) and operated by a public –private partnership that is designed to ensure that plan enrollees receive high-quality health care coverage without unnecessary costs.

"Standard benefits package" means a set of covered benefits with out-of-pocket cost-sharing limits and provider network rules, subject to the same coverage mandates that apply to small group health insurance sold in the state. It includes: (1) coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical, and occupational therapy; home health care; vision care; family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; identification and treatment of developmental delays from birth through age three; and evidence-based wellness programs; (2) a per individual and per family deductible that excludes drugs; (3) preventive care with no copayment; (4) prescription drug coverage with copayments; (5) office visits for other than preventive care with copayments, mental and behavioral health services coverage, including tobacco cessation services, substance abuse treatment services, and obesity prevention and treatment services (these services must have parity with coverage for physical health services); and (6) dental coverage.

"Employer-sponsored insurance" means a group health plan as defined by the federal Employee Retirement Income Security Act of 1974 (ERISA).

A "participating provider" is a licensed health care provider that agrees to provide nonemergency services to SustiNet members.

A "small employer" is a person, firm, corporation, limited liability company, partnership, or association actively engaged in business or self-employed for at least three consecutive months, which, on at least 50% of its working days during the preceding twelve months, employed up to 50 people, the majority of whom worked in the state. Small employers include a self-employed individual, a municipality procuring health insurance according to the Municipal Employee Health Insurance Plan (MEHIP; CGS § 5-259), a private school procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of private schools, and a nonprofit organization, a community action agency, or an association of personal care assistants procuring health insurance through MEHIP.

§ 2 — ESTABLISHING THE SUSTINET AUTHORITY

Board Members

The bill establishes the SustiNet Authority as a public instrumentality and political subdivision of the state deemed to perform an essential public and governmental function. The SustiNet Authority is governed by a nine member board of directors who must be appointed by August 15, 2009. The board members and appointing authority are as follows:

1. the governor appoints the chairperson, with the advice and consent of the House and Senate, who must be an expert in health economics for a two-year term;

2. the Senate president pro tempore appoints an expert on health care delivery, including primary care, for a two year term;

3. the House speaker appoints a representative of HUSKY beneficiaries for a three-year term;

4. The Senate majority leader appoints a representative of the Connecticut Hospital Association for a three-year term;

5. the House majority leader appoints a representative of the Connecticut State Medical Society for a four-year term;

6. the Senate minority leader appoints a representative of the Connecticut Nurses' Association for a four-year term;

7. the House minority leader appoints a representative of private employers for a five-year term; and

8. the "Coalition Committee" appoints two members, one representing labor unions and one representing business management (Coalition Committee apparently refers to the State Employee Bargaining Agent Coalition (SEBAC)). These members serve at the committee's pleasure.

The commissioners of the departments of Social Services (DSS), Public Health (DPH), Mental Health and Addiction Services (DMHAS) , Insurance (DOI), and the State Comptroller are ex-officio, non-voting members of the board.

Board Organization, Meetings, and Duties

After their initial terms, board members serve a five-year term. Board members can be reappointed when their term expires. The board annually elects a vice chairperson. Board members are not compensated, but can be reimbursed for expenses.

Six board members constitute a quorum. Resolutions must be passed by the majority of those present. Meetings are open to the public, with a public comment portion at each meeting, although the board can meet in executive session to discuss personnel and "proprietary" matters. Board meetings must be held in different locations throughout the state. It is subject to ethical and auditing

requirements and board members may have to abstain from deliberations and voting when they have a conflict of interest.

The board can delegate by resolution to three or more of its members such powers and duties as it deems proper. At least one of these members must not be a state employee.

The board, within available appropriations, must appoint an executive director who is not a board member and whose compensation is determined by the board. The compensation must reflect that typically paid in the private insurance industry for positions of comparable responsibility as determined by the board.

The board must also adopt procedures governing how it: (1) adopts an annual budget and operational plan; (2) hires, dismisses, promotes, and compensates employees; (3) approves non-budgeted expenditures over $5,000; (4) contracts for professional services which it must do at least once every three years (e.g., legal, financial, insurance); (5) awards loans and grants; and (6) contracts with insurers or other entities for administrative purposes, such as claims processing and credentialing of providers.

Surety Bonds

The bill requires each board member to execute a surety bond in the sum of $50,000, while the executive director and other authority officers must execute a $100,000 surety bond. In lieu of this, the board chairman may execute a blanket position bond covering each member, the executive director, and authority employees. This must be approved by the attorney general and filed with the secretary of the state. The authority must pay for the bonds.

§ 3 — PURPOSES AND POWERS OF THE SUSTINET AUTHORITY

Authority Purposes

The bill establishes the purpose of the authority and its responsibilities. Its purpose is to design and implement the "SustiNet Plan", a self-insured health care delivery plan, administered by the authority and operated by a public-private partnership, designed to

ensure that plan enrollees receive high quality health care coverage without unnecessary costs. All state and municipal agencies, departments, boards, commissions and councils must fully cooperate with the SustiNet Authority.

The purpose of the SustiNet Plan is to:

1. improve the health of state residents;
2. improve the quality of health care and access to health care;
3. provide health insurance coverage to Connecticut residents who would otherwise be uninsured;
4. increase the range of health care insurance coverage options available to residents and employers; and
5. slow the growth of per capita health care spending both in the short-term and in the long-term.

Authority Powers

Within available appropriations, the authority is authorized and empowered to:

1. have perpetual succession as a body politic and corporate and to adopt bylaws for regulation and conduct of its operations, adopt an official seal; and maintain an office at a place it designates;
2. sue and be sued;
3. adopt guidelines, policies and regulations necessary to implement the bill's provisions (other state quasi-public agencies are not authorized to adopt regulations);
4. invest any funds in specified ways (the authority may delegate its investment powers to the state treasurer);
5. contract with insurers or other entities for administrative

purposes, such as claims processing and credentialing of providers, taking into account their capacity and willingness to offer networks of participating providers both within and outside the state and their capacity and willingness to help finance the administrative costs involved in establishment and initial operation of the SustiNet plan and reimbursing them using per capita fees or other methods that do not create incentives to deny care;

6. solicit bids from individual providers and provider organizations to insure adequate provider networks and provide all SustiNet Plan members with excellent access to high-quality care throughout the state and, in appropriate cases, outside the state's borders;

7. establish appropriate deductibles, minimum benefit packages, and out-of-pocket cost-sharing levels for different providers that may vary based on quality, cost, provider agreement to refrain from balance billing SustiNet Plan members, and other factors relevant to patient care and financial sustainability;

8. commission surveys of consumers, employers, and providers on issues related to health care and health care coverage;

9. negotiate on behalf of providers participating in the SustiNet Plan to obtain discounted prices for vaccines and other health care goods and services;

10. contract for such professional services as financial consultants, actuaries, bond counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, consultants, and bio-ethicists as the board deems necessary;

11. purchase reinsurance or stop loss coverage, set aside reserves, or take other prudent steps that avoid excess exposure to risk in the administration of a self-insured plan;

12. enter into interagency agreements for performance of SustiNet

Plan duties that may be implemented more efficiently or effectively by a state agency, including DSS and the office of the state comptroller;

13. set payment methods for providers that reflect evolving research and experience both within the state and elsewhere, promote patient health, prevent unnecessary spending, and ensure sufficient compensation to cover the reasonable cost of furnishing necessary care;

14. arrange loans on favorable terms that facilitate the development of necessary health care infrastructure, including community-based providers of medical home services and community-based preventive care service providers;

15. arrange for reduced price consultants to help health care providers restructure their practices and offices to function more effectively and efficiently in response to changes in health care insurance coverage and service delivery attributable to the implementation of the SustiNet Plan;

16. arrange for continuing medical education courses for physicians, nurses, and other clinicians, including training in culturally competent delivery of health care services;

17. appoint advisory committees to successfully implement the SustiNet Plan, further the objectives of the authority, and secure necessary input from various experts and stakeholder groups;

18. establish and maintain an Internet web site that provides for timely posting of all public notices issued by the authority or the board and such other information the authority or board deems relevant in educating the public about the SustiNet Plan; and

19. perform other acts and activities necessary to carry the authority's purposes and powers under the bill.

§ 4 — SUSTINET PLAN

The board must develop the procedures and guidelines for the SustiNet Plan which must comport with these five Institute of Medicine (IOM) principles:

1. health care coverage should be universal;
2. health care coverage should be continuous;
3. health care coverage should be affordable to individuals and families;
4. the health insurance strategy should be affordable and sustainable for society; and
5. health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.

The board must adopt action plans with measurable objectives in such areas as:

1. effective management of chronic illness,
2. preventive care,
3. reducing racial and ethnic disparities in health care and health outcomes, and
4. reducing the number of uninsured state residents.

The board must (1) monitor the progress made toward achieving these objectives and modify the action plans as necessary and (2) identify all funding sources that will be used to establish and administer the SustiNet Plan. It must report to the legislature on these activities.

§ 5 — HEALTH INFORMATION TECHNOLOGY

The bill delineates how electronic health records will be established

for SustiNet members and how participating providers may gain access to hardware and approved software for interoperable electronic medical records. For these purposes, the bill defines:

1. "electronic medical record" as a record of a person's medical treatment created by a licensed health care provider and stored in an interoperable and accessible digital format;

2. "electronic health record" as an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization;

3. "subscribing provider" as a licensed health care provider that (a) either is a participating provider in the SustiNet plan or provides services in the state; and (b) agrees to pay a proportionate share of the cost of the goods and services described in this section, consistent with board-adopted guidelines; and

4. "approved software" as electronic medical records software approved by the board, after receiving recommendations from the information technology committee the bill establishes.

Information Technology Committee and Plan Developmen

The bill establishes an information technology committee to make a plan, subject to board approval, for developing, acquiring, financing, leasing, or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers.

The plan must include the development of a payment system that allows subscribing providers to pay for approved software and hardware and to receive other support services for the implementation of electronic medical records. Unless the board decides on an alternative financing method, capital acquisition costs must be funded through tax exempt bonds issued by the Connecticut Health and

Educational Facilities Authority (CHEFA). Subscribing providers repay these bonds.

Implementation is coordinated with DPH, Office of Health Care Access (OHCA), and other state agencies to ensure "efficiency and compatibility."

Software and Hardware Options and Availability

Within available appropriations, the board must (1) provide approved software to subscribing providers and participating providers, consistent with the bill's capital acquisition, technical support, reduced-cost digitization of existing records, software updating, and software transition procedures and (2) develop and implement procedures to ensure that individual providers and hospitals have access to hardware and approved software for interoperable electronic medical records and establishment of electronic health records for SustiNet Plan members.

The information technology committee must consult with technology specialists and health care providers to select software and hardware options that meet the needs of the full array of health care practices. The bill requires the authority to procure hardware, software, and services. Vendors must be chosen through competitive bidding. But it also requires the committee to negotiate with vendors to obtain reasonable prices. The committee must insure, to the extent feasible, that the recommended electronic medical records packages can interact with other pertinent practice management modules including patient scheduling, claims submission, billing, and tracking of laboratory orders and prescriptions

The committee must also seek systems that have features which will help support more efficient and effective health care delivery. These features help with the implementation of evidence-based medicine, chronic care management, and care coordination and must include to the maximum extent feasible:

1. automated patient reminders concerning upcoming

appointments;

2. recommended preventive care reminders;

3. automated provision of test results to patients;

4. decision support, including notice of recommended services not yet received by a patient;

5. notice of potentially duplicative tests;

6. notice of potential drug interactions and past adverse drug reactions to similar medications;

7. notice of possible violation of patient wishes for end-of-life care; and

8. notice of services provided inconsistently with care guidelines.

Approved software must be able to gather information to help the authority assess health outcomes and track the accomplishment of clinical care objectives. The board must ensure that SustiNet Plan providers who use approved software are able to electronically transmit to, and receive information from, all laboratories and pharmacies participating in the plan, without the need to construct interfaces other than those constructed by the authority.

System Integration

The information technology committee must establish, within existing appropriations, a system of integrating information from subscribing providers' electronic medical records systems into a single electronic health record for each SustiNet Plan member. This integrated record must be updated in real time and accessible to any participating or subscribing provider serving the member.

The bill requires the board to establish guidelines for safeguarding privacy and data security, which include remedies and sanctions in cases where guidelines are not followed.

Condition of Participation in SustiNet

Under the bill, use of electronic medical records becomes a condition of provider participation in the SustiNet plan by July 1, 2015, with possible time extensions or exemptions made for special hardships for providers who do not meet the timeframe and whose participation in SustiNet is necessary to assure geographic access to care.

The bill includes specific incentives to help providers meet the goal of adoption of electronic medical records by July 1, 2015. The board must:

1. negotiate with one or more vendors to provide reduced-cost digitization of paper records;

2. help providers transition to another package "free of additional charge" if one of the approved packages is no longer satisfactory;

3. within available appropriations, hire or contract with health information technology professionals to provide training and technical assistance to subscribing health care providers;

4. provide technical assistance for providers who had previously implemented electronic medical or health records systems to transition to new software or assure existing software can connect and integrate;

5. share systemic cost savings achieved by implementing electronic medical and health records with subscribing providers. The amount of savings the board shares with a provider is limited to the amount of net financial loss experienced by the provider due to the implementation process;

6. offer implementation incentives, such as discounted fees, for early subscribers;

7. structure electronic health records to encourage the provision of

medical home functions (see below). Electronic health records must generate automatic notices to medical homes that: (a) report when an enrolled member receives services outside the medical home, (b) describe member compliance or noncompliance with provider instructions, and (c) identify the expiration of refillable prescriptions.

§ 6 — MEDICAL HOMES

Medical Home Advisory Committee

The bill establishes a Medical Home Advisory Committee composed of physicians, nurses, consumer representatives and other qualified individuals to develop procedures and proposed regulations for the operation of medical homes. The committee must forward these to the board.

Medical Home Functions

Under the bill, the board defines medical home functions on an ongoing basis, incorporating evolving research on delivery of health care services. If provider infrastructure limits prevent all SustiNet plan members from enrolling in a medical home, then enrollment in medical homes must be implemented in phases with priority given to members where cost savings appear most likely, including members with chronic health conditions.

Under the bill, the he functions of a medical home include:

1. Assisting members to safeguard and improve their own health by:
    a. advising members with chronic health conditions on how to monitor and manage their conditions;
    b. working with members to set and accomplish goals related to exercise, nutrition, use of tobacco, among other behaviors;
    c. implementing best practices to insure members understand and follow medical instructions; and

d. providing translation services and culturally competent communication strategies.

2. Care coordination that includes:
   a. managing transitions between home and hospital;
   b. proactive monitoring to ensure members receive all recommended primary and preventive care services;
   c. providing basic mental health care, including screening for depression, with referral for those who require additional assistance;
   d. addressing workplace, home, school, and community stress;
   e. Referring to nonmedical services such as housing, nutrition, domestic violence programs, support groups; and
   f. Ensuring information about members with complex health conditions is shared when multiple providers are involved and that they follow a single integrated treatment plan; and
3. Providing 24 hour access by telephone, secure email or quickly scheduled office appointments in order to reduce the need for hospital emergency room visits.

The board can assist in developing community-based resources to enhance medical home functions, including linguistically and culturally competent member education and care coordination. This can include hiring or contracting with necessary staff and arranging for low-interest loans that support development of community-based entities capable of fulfilling medical home functions.

Health Care Providers Who Can Serve as a Medical Home

Under the bill, a licensed health care provider who is capable of providing all core medical home functions as prescribed by the board can serve as a medical home. A group practice or community health center serving as a medical home must identify, for each member, a lead provider with primary responsibility for the member's care. In

appropriate cases, as determined by the board, (1) a specialist may serve as a medical home and (2) a patient's medical home may temporarily be with a health care provider who is overseeing the patient's care for the duration of a temporary medical condition, including pregnancy.

Each medical home provider must be given a list of all medical home functions, including patient education, care coordination, and 24 hour accessibility. If a provider does not wish to perform, within his or her office, certain functions outside core medical home functions, the provider must arrange for other qualified entities or individuals to perform these functions in a way that integrates them into the medical home's clinical practice. The authority must assist the provider with this. These qualified entities or individuals may be employed by or under contract with the authority, health care insurers, or other individuals. They must be certified by the authority based on the quality, safety, and efficiency of the service they provide. The authority must make all arrangements required for a qualified entity or individual to perform any medical home function (not just non-core functions) the core provider does.

Reimbursement

Medical home functions are reimbursable. The authority must set payment levels for those that are not normally reimbursed by commercial insurers, using different possible rate-setting mechanisms, including using Medicare rate-setting methods or setting a monthly case management fee.

The medical home provider must discuss possible referral with the specialist to determine if it is medically indicated and if so, what tests should be done in advance. This consultation is reimbursable.

§ 7 — HEALTH CARE PROVIDER COMMITTEE; CLINICAL CARE AND SAFETY GUIDELINES

The bill requires the board to establish a health care provider committee to develop clinical care and safety guidelines for use by participating health care providers. The committee must choose from

existing nationally and internationally recognized care guidelines. It must continually assess the quality of evidence, the relevant costs, and the risks and benefits of treatments. It must forward its recommendations to the board. The committee must have provider and consumer members.

Under the bill, SustiNet providers must receive confidential reports comparing their practice patterns with their peers. The report must include opportunities for continuing education.

The board, in consultation with the committee, must approve quality of care standards for particular medical conditions. Such standards may reflect outcomes over the entire care cycle for each health care condition, adjusted for patient risk and general consistency of care with approved guidelines and other factors. Providers who meet or exceed the standards for a particular condition must be publicly recognized and made known to SustiNet members, including those who have been diagnosed with that particular medical condition.

The board must develop procedures requiring hospitals to periodically conduct quality of care reviews and develop quality of care improvement plans. Such reviews must include the identification of potential problems manifesting as adverse events or events that could have resulted in negative patient outcomes. As appropriate, they must incorporate confidential consultation with peers and colleagues, opportunities for continuing medical education, and other interventions and supports to improve performance. To the maximum extent permissible, the reviews must incorporate existing peer review mechanisms and are subject to the law's protections concerning peer review (CGS § 19a-17b).

The board, in consultation with hospitals serving SustiNet plan members, must develop safety standards for implementation in these hospitals. It must establish procedures to monitor and impose sanctions to ensure compliance with the standards. The board may also establish performance incentives to encourage hospitals to exceed such safety standards.

The board may provide participating providers with information about prescription drugs, medical devices, and other goods and services used in health care delivery. This information can address emerging trends involving the use of goods and services that the board judges are less than optimally cost effective. The board may give participating providers free samples of generic or other prescription drugs. It may also use procedures and incentives to encourage participating providers to furnish SustiNet members with appropriate evidence-based health care.

§ 8 — PREVENTIVE HEALTH CARE AND COMMUNITY-BASED PREVENTIVE HEALTH INFRASTRUCTURE

The bill requires the board to establish a "Preventive Health Care Committee" to make recommendations to improve health outcomes for members in areas of nutrition, physical exercise, tobacco use, addictive substances, and sleep, taking into account programs already underway in the state. The committee must include providers, consumers, and others chosen by the board. These recommendations may be targeted to special member populations where they are most likely to benefit members' health. They can include behavioral components and financial incentives for participants. By July 1, 2010 and annually afterward, the committee must submit its recommendations to the board and to the Public Health, Appropriations, and Finance, Revenue, and Bonding committees.

The bill requires all SustiNet plans sold to employers or individuals to cover community-based preventive care services that can be administered safely in community settings. Examples of these services are immunizations, simple tests, and health care screenings and examples of locations are workplaces, schools, or other community locations. Under the bill, community-based preventive care providers must use the patient's electronic health record to confirm that the service is needed and is not contra-indicated. They must furnish test results or documentation of the service to the patient's medical home or primary care provider.

§ 9 — ENROLLMENT OF VARIOUS GROUPS IN SUSTINET

State Employees, Retirees

Under the bill, as of July 1, 2011, SustinNet becomes the only source of health care coverage for qualified state employees and retirees and their dependents, including those who would have qualified under laws in effect on January 1, 2009. The SustiNet benefits, access to providers and cost-sharing rules must be consistent with collective bargaining agreements. The "coalition committee" retains jurisdiction over policy and practice matters that pertain exclusively to coverage for state employees and retirees, and may overrule any board decision concerning them that would reduce benefits or access to care, or increase enrollee costs.

HUSKY PLAN Part A and B Beneficiaries

The board must develop policies and procedures to ensure that HUSKY Plan part A and part B beneficiaries enroll in SustiNet. The policies and procedures must minimally provide that, to the extent permitted by federal law:

1. HUSKY beneficiary enrollment is phased in between July 1, 2011, and June 30, 2013;

2. be phased in geographically at the board's discretion;

3. provider reimbursement must gradually increase so that on or after July 1, 2011 per member per month costs calculated separately for children and adults do not fall below the percentages of median costs for large group coverage in the state (the bill does not define "large group");

4. there is no reduction in HUSKY A, B, Medicaid, or SAGA benefits or increase in out of pocket cost sharing or premiums for people who qualified or would have qualified for benefits as of January 1, 2009; and

5. SustiNet does not enroll HUSKY plan part A beneficiaries who qualify for (a) Medicare, (b) Supplemental Security Income, or

(c) any category of Medicaid eligibility based on a disability, provided this exemption does not apply to any person who intermittently qualifies for Medicaid as medically needy based on incurring medical bills for services not involving long-term care.

Those Not Offered Employee Sponsored Insurance (ESI)

Under the bill, people not offered employer sponsored insurance **(**ESI**)** can enroll in SustiNet beginning July 1, 2011. Those above 300% of the federal poverty level (FPL) (i.e., not HUSKY-eligible) will be offered a standard benefits package with the option to purchase additional benefits at their full cost.

Anyone above 400% of FPL pays the full cost of premiums. Those with pre-existing conditions who have had continuous coverage cannot be excluded and will not have a waiting period for their pre-existing conditions to be covered. Enrollment within 60 days is considered continuous coverage. Those without continuous coverage who do not enroll within that period may be charged an increased premium.

Those between 301% and 350% FPL receive a subsidy to reduce premiums to 5% of household income at 300% of FPL. Those between 351% and 400% FPL receive a subsidy to reduce premiums to 7% of household income at 350% of FPL.

The authority will investigate the possibility of having premiums withheld and deposited directly into the SustiNet account. Unpaid premiums must be added to the individual's state income tax liability, including interest and penalties.

Those Offered Unaffordable or Inadequate ESI

The board must develop policies and procedures to give certain state residents who are offered ESI the option to enroll in SustiNet. This option is available on and after July 1, 2011. To be eligible for this option: (1) an individual must be ineligible for Medicare and (2) (a) the individual has family income at or below 400% FPL and the cost of the

employee's share of premiums is more than 2% of household income above what the individual would pay for enrolling in SustiNet, (b) the individual's diagnosed health conditions make it highly probable that he or she will incur out-of-pocket costs over 7.5% of household income, or (c) the actuarial value of the individual's ESI is less than 80% of the median actuarial value of health coverage offered by large employers in the Northeast. The board must establish a simplified enrollment procedure for those individuals who can enroll in the SustiNet plan under these provisions.

Employees who are covered by SustiNet under this method will still count toward the employer's "minimum participation" requirements for purchasing group coverage. When an employee enrolls in SustiNet through this method, his or her employer must pay SustiNet the money the employer would have paid for the individual's insurance in the form of an employer voucher payment.

Voucher payments are limited in two ways: (1) the total of employees who accept employer coverage and those for whom a firm makes voucher payments may not exceed the average percentage of workers and dependents who accept employer coverage offers at firms in the Northeast of the same general size and industry and (2) the cost of employer vouchers, plus the amount the employer pays for employer-sponsored insurance premiums cannot exceed what the employer would have paid for employer-sponsored health care coverage but for the implementation of the bill's provisions.

If the above described cap does not succeed in preventing vouchers from increasing an employer's health insurance costs, the employer may bring an appeal to reduce the required number of vouchers. An employer prevailing in such an appeal is granted costs and attorney's fees.

For an individual enrollee required to pay premiums to the SustiNet plan: (1) the authority must consult with the Department of Revenue Services (DRS) to develop and implement methods of withholding premium payments from the individual's paycheck and depositing the

payments directly into the SustiNet account (see § 15) and (2) the amount of any unpaid premiums during a calendar year must be added to the individual's state income tax liability, with interest and penalties determined by treating the unpaid premium payments as state income tax obligations. Before DRS is informed of the enrollee's unpaid premiums, the board must provide the enrollee notice and an opportunity to be heard in order to challenge the board's determination that he or she did not pay the premiums or to allow the enrollee to arrange payment terms satisfactory to the board that do not involve a referral to DRS. The board and DRS must develop procedures through which the additional income tax payments made under this provision are forwarded to the SustiNet account.

§ 10 — OFFERING SUSTINET TO EMPLOYERS THROUGH EXISTING CHANNELS

The bill permits the authority to use various ways to sell SustiNet to employers, including public and private purchasing pools, agents, and brokers. It can offer multi-year contracts that have predictable premiums. The board must establish policies and procedures to ensure that employers can easily and conveniently purchase SustiNet plan coverage for their workers and dependents. These policies and procedures may include participation requirements, timing of enrollment, open enrollment, enrollment length, and other matters deemed appropriate by the board. The board must develop policies and procedures to prevent adverse selection. "Adverse selection," in this context, means purchase of SustiNet Plan coverage by employers with unusually high-cost employees and dependents under circumstances where premium payments do not fully cover the probable claims costs of the employer's enrollees.

Small employers (up to 50 employees, see definition in § 1)) can purchase SustiNet beginning on July 1, 2011. Small group rating rules apply for setting premiums.

Larger employers can begin offering SustiNet on July 1, 2015. Further, to prevent adverse selection, SustiNet can take past claims

experience and other employee and dependent characteristics into account in setting premiums, just as is done now in the insurance market for these types of employers. All employer premiums are subject to increases if premiums the previous year did not cover the group's costs. Increases must be applied uniformly to all employees with single-year contracts.

Both small and larger employers will be offered the standard benefits package. The authority can offer other benefits packages which cannot be any less comprehensive than the model benefits packages established by the bill in § 16.

§ 11 — INFORMATION CLEARINGHOUSE

The bill establishes an independent information clearinghouse to provide employers, individual consumers, and the general public with information about the care covered by the SustiNet Plan and by private health plans**.** The Office of the Healthcare Advocate (OHA) is responsible for establishing the clearinghouse and contracting with an independent research organization to operate it.

The purpose of the clearinghouse is to offer comparative information about quality of care, health outcomes for particular health conditions, access to care, patient satisfaction, adequacy of provider networks, and other performance and value information. The act charges OHA with developing such specifications.

The SustiNet Plan and health insurers must submit data to the clearinghouse, the latter as a licensing condition. Self-insured group plans may provide data voluntarily. Dissemination of information provided by any self-insured plan is limited, based on negotiations between the clearinghouse and the plan.

The clearinghouse must begin making its information public by August 1, 2012 and update it annually. It must avoid disseminating information that identifies individual patients or providers. To the extent possible, it must also adjust health outcomes based on patient risk levels so that provider outcome performance is more accurately

captured.

§ 12 — UNFAIR COMPETITION

The bill discourages intentional interference with fair and open competition between SustiNet, ESI coverage, and any individual or group insurance sold in the state. In addition to other applicable penalties, the bill subjects breaches of this section to the same penalties that apply to bribery of officials.

§ 13 — EXPANSION OF MEDICAID AND HUSKY ELIGIBILITY

The act directs the DSS commissioner, to the extent allowed by federal law, to take all necessary steps to ensure that beginning July 1, 2011, HUSKY A includes all adults with incomes below 185% of the FPL, whether or not they are the custodial parents or caretaker relatives of minor children.

The bill also directs the commissioner to make adults with incomes from 186% to 300% FPL eligible for HUSKY B beginning July 1, 2011. Benefit levels and cost-sharing responsibilities for these adults must be comparable to those for households with children in HUSKY part B at the same income level. After accounting for differences in utilization between adults and children, it requires adults to be charged premiums that are no less than twice the amount charged to the household of a child enrolled at the same income level, calculated as a percentage of the federal poverty level.

Under the bill, beginning July 1, 2011 and to the extent allowed by federal law, immigration status cannot be a factor in determining eligibility for the HUSKY Plan A or B, or for SustiNet subsidies. The SustiNet Authority and DSS must obtain the maximum federal matching funds possible.

§ 14 — INDIVIDUAL MARKET REFORMS

The bill specifies that on or after July 1, 2011, the same rating rules existing in the small group market must apply in the individual market. Pre-existing conditions may not be excluded, except where it would be permitted if the policy were sold in the small group market

(i.e., based on gaps in continuous health coverage before enrolling in health insurance).

§ 15 — SUSTINET ACCOUNT AND FUNDING SOURCES

The bill establishes a separate, nonlapsing General Fund account (the "SustiNet Account") for claims payment and related administrative costs. The bill charges the SustiNet Authority and DSS with ensuring that the costs of providing Medicaid, HUSKY Plan and SustiNet premium subsidies, as well as administrative costs, are sufficiently covered by deposits into the account.

It directs the authority to work with DSS to maximize the amount of federal funds used to help finance Medicaid, HUSKY, and SustiNet premium subsidies. DSS must seek any Medicaid and State Children's Health Insurance Plan waivers that are needed for the effective implementation of the bill. This includes a waiver to obtain the maximum amount possible in federal matching funds to provide coverage to childless adults.

The authority must determine premiums for individual enrollees and ensure premium payments are deposited in the SustiNet account.

Beginning January 1, 2012, the bill creates a shared responsibility requirement for employers who do not offer ESI coverage and their employees. These employers must pay a percentage of total payroll above a threshold amount established annually by DRS equal to the average payroll for a Connecticut employer with 10 employees.

For limited liability companies, S-corporations, and similar business entities "payroll" means income that is subject to federal payroll or federal self-employment taxation.

If an employer has total payroll above the threshold amount, and does not provide employer-sponsored coverage, the employer must make a shared responsibility payment equal to 3% of the employer's payroll above the threshold amount. The employees of such employers must collectively make annual shared responsibility payments of 1% of

the employers' payroll that is above the threshold amount.

Employer and employee payments go into the SustiNet account. DRS must consult with the SustiNet board to develop policies and procedures for collecting shared responsibility payments through a modification of the existing payroll tax collection system.

The bill requires the state to deposit "maintenance of effort" payments into the SustiNet account. The SustiNet board must report annually, beginning December 31, 2009, to the governor , comptroller, and the Public Health, Human Services, Labor and Public Employees, and Appropriations committees on certified estimates of the maintenance of effort payment estimates needed for the succeeding two fiscal years. It must calculate maintenance of effort amounts equal to health care expenditures the state would have incurred under current law for state employees and retirees and for HUSKY, if not for SustiNet.

§ 16 — VALUE-BASED BENEFITS DESIGN

The bill requires OHA to develop model benefit packages that contribute the greatest possible amount of health benefit for enrollees, based on medical and scientific evidence, for the premium cost typical of private, employer-sponsored insurance in the northeast. By December 1, 2010, and then biennially, the office must report to the board and to the Public Health, Human Services, Labor and Public Employees, Appropriations, and Finance, Revenue and Bonding committees on the updated model benefits package. It may contract with an independent research organization for assistance.

After receiving these models, the SustiNet board may adjust the standard benefit package if it believes an adjustment would either yield better health outcomes for the same expenditure of funds, or provide additional health benefits or reduced cost-sharing for particular groups that justify an increase in net costs.

OHA must recommend guidelines for an incentive system to recognize employers who provide employees with benefits that are

equivalent to or better than the model benefit packages.

By December 1, 2010, the office must report on these guidelines and recommendations to the governor, comptroller, and the Public Health, Labor and Public Employees, and Appropriations Committees.

§ 17 — PUBLIC EDUCATION AND OUTREACH CAMPAIGNS

The bill requires the SustiNet Authority board to establish public education and outreach campaigns to inform the public of SustiNet's availability and encourage enrollment. Community based organizations must be used to reach underserved populations. The campaign must be based on evidence of the cost and effectiveness of similar efforts in this state and elsewhere. The campaign must have an ongoing evaluation of its effectiveness, and changes in strategy as needed.

§ 18 — AUTOMATIC ENROLLMENT

The SustiNet board, in collaboration with state and municipal agencies, must, within available appropriations, develop systems to identify uninsured individuals and determine their eligibility for HUSKY coverage, SustiNet premium subsidies, or other sources of coverage, and to enroll them promptly into health insurance coverage. These systems must be in place by July 1, 2011. Three primary mechanisms to identify the uninsured must be employed:

1. By July 1, 2011, state income tax forms must, within available appropriations, be modified to request that taxpayers identify existing health coverage for each household member. DRS will, within available appropriations, notify taxpayers that restricting disclosure of income information may impede them from obtaining free or low-cost health coverage. DRS must provide the SustiNet board and DSS the necessary information for DSS to determine income eligibility and to automatically enroll the taxpayer into coverage for which he or she is eligible.

2. By July 1, 2011, the Department of Labor (DOL) must, within available appropriations, modify its unemployment insurance

claims forms to request information about health insurance status for the applicant and his or her dependents. Applicants must be informed that this information will be shared with the SustiNet board and DSS.

3. By July 1, 2011, the SustiNet Board, in collaboration with DSS, must develop a method by which hospitals, community health centers, and other health care providers will identify uninsured individuals who seek health care, and transmit information to DSS. SustiNet must reimburse such health care providers retroactively for the cost of care if the individual is enrolled in SustiNet.

The SustiNet board, in collaboration with DSS and within available appropriations, must develop procedures to cross-reference databases of state residents with databases of residents with health insurance coverage. Beginning July 1, 2011, before enrolling any individual who appears to be uninsured in a state-administered health plan, the identity of the person must be cross-matched to confirm his or her insurance status. The board must develop notice and hearing procedures that allow people to contest a determination concerning insurance coverage status.

Beginning July 1, 2011, when an individual is determined to be uninsured, the SustiNet board must notify him or her in writing that he or she will be enrolled in health insurance coverage, with premiums based on income, unless the individual opts out of coverage. Premium payments are due and payable within 45 days of this notice. Individuals have 45 days to contest the determination that they are uninsured and provide proof of coverage or affirmatively opt to remain uninsured.

Income verification must be done by matching the individual with all accessible, cost-effective sources of information concerning the individuals' income. Individuals can challenge an initial income determination and demonstrate lower income that lowers the cost of health insurance coverage through SustiNet.

The initial health insurance premium invoice must be accompanied by a notice of the final opportunity to opt out of health insurance coverage. Individuals have 50 days from receiving the invoice to do this. An individual opting out will be disenrolled and will not be liable for past due premium payments.

The SustiNet board must provide written information to all individuals it determines are uninsured about the potential risks of remaining uninsured. Individuals who decide to opt out must notify the SustiNet board in writing of their choice to remain uninsured. The decision to remain uninsured is effective for no more than one year and must be renewed annually in writing.

Under the bill, a person who does not have access to ESI must be enrolled in SustiNet. An individual with access to ESI must enroll in it unless it is unaffordable or inadequate, in which case he or she can enroll in SustiNet or they can opt out of insurance as the bill provides.

Automatic enrollment procedures must be phased in beginning January 1, 2011 through July 1, 2014. The bill gives the board discretion to determine the phase-in approach and modify it as needed.

§ 19 — IDENTIFYING UNINSURED CHILDREN

The bill directs the DSS and education commissioners, in consultation with the SustiNet Authority Board to jointly establish procedures for sharing data from the National School Lunch Program to identify income eligible children for enrollment in the SustiNet Plan or HUSKY A and B.

§ 20 — ELIGIBILITY REDETERMINATION

Under the bill, the SustiNet Board and DSS must ensure that the redetermination of eligibility for SustiNet premium subsidies and for continued coverage in HUSKY A or B is convenient, consumer friendly, and safeguards privacy. The redetermination process must be designed in a manner that it is consistent with obtaining federal matching funds.

Eligibility for SustiNet premium subsidies or enrollment in HUSKY must be certified for a 12-month period. Changes in household circumstances (loss of income, loss of health insurance coverage, divorce, re-marriage, etc.) during this period cannot adversely affect eligibility. But depending on the nature of the changed circumstances, individuals may qualify for less costly coverage or additional benefits.

The bill requires DSS, when claiming federal matching funds based on immigration status, to the extent permitted by federal law, to base them on statistically valid caseload samples and data matches with federal authorities rather than requiring applicants to provide documents.

DSS, when redetermining eligibility for the HUSKY A and B, and for SustiNet premium subsidies, must minimize procedural terminations of benefits through use of administrative renewals, ex-parte renewals, and telephonic renewals.

§ 21 — EVALUATING OUTCOMES AND MAKING POLICY AND PROCEDURAL CHANGES

Under the bill, the board is responsible for monitoring health care delivery system improvements under SustiNet and making policy and practice adjustments based on best practice evidence.

The board must examine electronic health records to identify outstanding medical practices and factors contributing to outstanding performance and incorporate them into the SustiNet plan. Electronic health records must also be used to evaluate comparative effectiveness of alternative treatments.

The board must regularly evaluate:

1. the application and enrollment process;

2. access to, utilization of, and quality of health care;

3. overall health status of SustiNet members; and

4. the effectiveness of any policies and practices that are revised.

The board must use these evaluations to revise policies and practices to improve outcomes for members or vulnerable subsets of members.

If, in evaluating performance, the board judges that the SustiNet Plan is causing a significant shift of insurance coverage responsibility from employers to consumers or to the public sector ("crowd out"), it may modify plan coverage to remedy the situation. Remedies can include modifying eligibility criteria for SustiNet premium subsidies and adult coverage through HUSKY B. However, those individuals qualifying for state-sponsored coverage under current law cannot be affected by such modifications.

The board can also revise the terms and conditions of SustiNet enrollment if it (1) judges that the plan is experiencing significant harm from "adverse selection," (2) significant numbers of people are receiving inadequate employer-sponsored coverage, and (3) large numbers of people are deterred from enrolling in SustiNet because of its cost. In this case, the board can increase premium subsidies.

Before the board implements a policy decision it must, after newspaper, internet, and other notice, conduct a public hearing to obtain public input on the proposed revision. The board must monitor federal law, regulations, and policies to make recommendations to the General Assembly for any necessary or advisable changes to the bill as needed.

§ 22 — AUTHORITY REPORTING REQUIREMENTS

The SustiNet Authority must report annually to the appointing authorities of the board of directors and to the Public Health, Human Services, Labor and Public Employees, Appropriations, and Finance, Revenue and Bonding committees, starting December 1, 2010. The board must report in detail on the state of health care in the state and on the implementation of the SustiNet Plan. The report must include recommendations for legislative changes concerning the

administration of the SustiNet Plan.

Each report filed on or after December 1, 2011 must include:

1. general trends in coverage, health outcomes, quality, and access for SustiNet Plan members;

2. health care provider workforce issues;

3. the extent to which ESI provides affordable access to necessary health care for employees and their dependents, including those with low incomes and health problems, along with policy options for addressing any problems identified; and

4. whether provider networks are sufficient to furnish all SustiNet Plan members with "excellent access" to care and if not, proposals to address this.

Each report filed on or after December 1, 2012 must include: (1) recommendations as to whether SustiNet Plan coverage should be extended to Medicare enrollees who are not state retirees; (2) a recommendation as to whether plan coverage should be extended to include Medicaid enrollees who are not enrolled in SustiNet due to age or disability; (3) whether SustiNet implementation has caused a cost shift from employers to taxpayers and if so, proposals to fix this; (4) whether additional changes to individual market regulation are needed; and (5) whether shared responsibility payments should be modified to reflect an employer's ability to pay based on size, wage level, industry, and other factors.

Reports filed on or after December 1, 2013 must indicate whether deficits or excesses in the physical infrastructure of the health care system are increasing health care costs without yielding corresponding gains in health outcomes, and if so, proposals to remedy this.

Each report filed after December 1, 2014 must address the effectiveness of the state's voluntary system of providing health care coverage to all state residents, including those who are young and

healthy, and the advantages and disadvantages of mandating each resident to obtain coverage.

§ 23 — SUSTINET AUTHORITY AS A QUASI-PUBLIC AGENCY

The bill makes the SustiNet authority a "quasi-public agency."

§ 24 — INDEMNIFICATION OF THE SUSTINET AUTHORITY AND ITS DIRECTORS, OFFICERS, CONTRACTORS, AND EMPLOYEES

The bill requires the state to protect, hold harmless, and indemnify the SustiNet Authority and its directors, officers, contractors, and employees from financial loss and expense, including legal costs, arising out of any claim, demand, suit, or judgment based on any alleged act or omission in connection with, or any other legal challenge to, the SustiNet Plan. This protection applies if the individuals are found to have been acting in the discharge of their duties or within the scope of their employment and the act or omission is not found to be wanton, reckless, willful, or malicious.

§ 25 — ERISA JURISDICTION

The bill specifies that no state court has jurisdiction to hear a claim that any of the bill's provisions violates the Employee Retirement Income Security Act of 1974 (ERISA).

§ 26 — ENFORCEABILITY OF PROVISIONS

The bill provides that if any of its provisions or their applicability is held invalid by a court of competent jurisdiction, the remaining provisions are not affected.

§ 27 — OBESITY TASK FORCE

The bill creates a task force to study childhood and adult obesity. It must examine evidence-based strategies for preventing and reducing obesity and develop a comprehensive plan that will result in a reduction in obesity.

The task force includes the following members:

1. a representative of a consumer group with expertise in

childhood and adult obesity, appointed by the House speaker;

2. two academic experts in childhood and adult obesity , one each appointed by the Senate president pro tempore and the governor;

3. two representatives of the business community with expertise in the subject, one each appointed by the House majority and minority leaders; and

4. two health care practitioners with expertise on the topic, one each appointed by the Senate majority and minority leaders.

These members may be members of the General Assembly.

The commissioners of public health, social services, and economic and community development and a representative of the SustiNet board are ex-officio, non-voting members. Appointments must be made within 30 days after the effective date of this provision. Vacancies are filled by the appointing authority. The members appointed by the House speaker and the Senate president pro tempore serve as chairpersons. The first meeting must be held within 30 days after the bill's effective date. The Public Health committee staff serves as the task force's administrative staff.

By July 1, 2010, the task force must report to the Public Health, Human Services, and Appropriations committees. The task force terminates when the report is submitted or January 1, 2011, whichever is later.

§ 28 — TOBACCO USE TASK FORCE

The bill establishes a task force to study tobacco use by children and adults. It must examine evidence-based strategies for preventing and reducing tobacco use and developing a comprehensive plan to cause a reduction in tobacco use by children and adults.

Its members are as follows:

1. a representative of a consumer group with expertise in tobacco use by children and adults, appointed by the House speaker;

2. two academic experts in the field, one each appointed by the Senate president pro tempore and the governor;

3. two representatives of the business community with expertise on the topic, one each appointed by the House majority and minority leaders;

4. two health care practitioners with expertise in the field, one each appointed by the Senate majority and minority leaders.

These task force members may be legislators.

The commissioners of public health, social services, and economic and community development and a representative of the SustiNet board are ex-officio, non-voting members. Appointments must be made, vacancies filled, and meetings held as described for the obesity task force. The chairpersons are the members appointed by the House speaker and the Senate president.

By July 1, 2010, the task force must report to the Public Health, Human Services, and Appropriations committees. It terminates when it submits the report, or January 1, 2011, whichever is later. The Public Health Committee staff serves as administrative staff.

§ 29 — HEALTH CARE WORKFORCE TASK FORCE

The bill establishes a task force to study the state's health care workforce. It must develop a comprehensive plan for preventing and remedying state-wide, regional, and local shortages of necessary medical personnel. Its members are as follows:

1. a representative of a consumer group with expertise in health care, appointed by the House speaker;

2. two academic experts on health care workforce, one appointed by the Senate president pro tempore, and the other by the

governor;

3. two representatives of the business community with expertise in health care, one each appointed by the House majority and minority leaders; and

4. two health care practitioners, one each appointed by the Senate majority and minority leaders.

The commissioners of public health, social services, and economic and community development, the president of UConn, the chancellors of the Connecticut State University System and the regional Community-Technical Colleges , and a representative of the SustiNet board are ex-officio, non-voting members. Legislators may be on the task force. Appointments must be made, vacancies filled, and meetings held as described above for the previous two task forces. The chairs are the members appointed by the House speaker and the Senate president.

The Public Health Committee staff serves as administrative staff for the task force. The task force must report, by July 1, 2010, to the Public Health, Human Services, and Appropriations committees. The task force terminates as described above.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 22 Nay 8 (03/26/2009)