House of Representatives

General Assembly

File No. 920

January Session, 2009

Substitute House Bill No. 6600

House of Representatives, May 8, 2009

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th 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 16, inclusive, of this act and section 17b-297b of the general statutes, as amended by this act:

(1) "SustiNet Plan" means a self-insured health care delivery plan, administered by the public 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;

(2) "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 public 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 public 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 public authority;

(E) Prescription drug coverage with copayments as determined by the public 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 public 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;

(3) "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;

(4) "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;

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

(6) "Board of directors" means the SustiNet Health Partnership board of directors established pursuant to section 2 of this act;

(7) "Public authority" means the public authority recommended by the SustiNet Health Partnership board of directors in accordance with the provisions of subsection (c) of section 3 of this act; and

(8) "Small employer" has the same meaning as provided in subparagraph (A) of subdivision (4) of section 38a-564 of the general statutes.

Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is established the SustiNet Health Partnership board of directors. The board of directors shall consist of fourteen members, as follows: The Comptroller or the Comptroller's designee; the Healthcare Advocate, or the Healthcare Advocate's designee; one appointed by the Governor, who shall be a representative of an employer-based association; one appointed by the Lieutenant Governor, who shall be a representative of an employer with fifty or fewer employees; two appointed by the president pro tempore of the Senate, one of whom shall be an expert on health care delivery, including primary care delivery and one of whom shall be experienced with health care information technology systems; two appointed by the speaker of the House of Representatives, one of whom shall be a representative of Medicaid and HUSKY Plan

beneficiaries and one of whom shall be a representative of a nonprofit health care advocacy association; 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. In addition, the Commissioners of Social Services, Public Health and Mental Health and Addiction Services and the Insurance Commissioner shall be ex-officio, nonvoting members of the board of directors. The Comptroller and the Healthcare Advocate, or their designees, shall serve as the chairpersons of the board of directors.

(b) Initial appointments to the board of directors shall be made on or before July 15, 2009. In the event that an appointing authority fails to appoint a board member by July 15, 2009, the president pro tempore of the Senate and the speaker of the House of Representatives shall jointly appoint a board member meeting the required specifications on behalf of such appointing authority and such board member shall serve a full term. The presence of not less than seven members shall constitute a quorum for the transaction of business. The initial term for the board members appointed by the Governor, Lieutenant 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. Any member of the board may be removed by the appropriate appointing authority for misfeasance, malfeasance or wilful neglect of duty.

(c) The SustiNet Health Partnership board of directors shall not be construed to be a department, institution or agency of the state.

Sec. 3. (NEW) (*Effective July 1, 2009*) (a) The SustiNet Health Partnership board of directors shall design and establish implementation procedures to 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) Not later than January 1, 2011, the SustiNet Health Partnership board of directors shall submit its design and implementation procedures in the form of recommended legislation to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and finance, revenue and bonding.

(c) The SustiNet Health Partnership board of directors shall offer recommendations on matters that include, but are not limited to, the establishment of a public authority 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 16, 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 public authority determines. The public 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 public authority to successfully implement the SustiNet Plan, further the objectives of the public 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 public authority or the board of directors and such other information as the public authority or board deems relevant in educating the public about the SustiNet Plan;

(22) To raise funds from private and public sources outside of the state budget to contribute toward support of its mission and operations;

(23) To make optimum use of opportunities created by the federal government for securing new and increased federal funding, including, but not limited to, increased reimbursement revenues;

(24) In the event of the enactment of federal health care reform, to submit preliminary recommendations for the implementation of the SustiNet Plan to the General Assembly not later than sixty days after the date of enactment of such federal health care reform; and

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

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

Sec. 4. (NEW) (*Effective July 1, 2009*) (a) The board of directors 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 of directors shall identify all potential funding sources that may be utilized to establish and administer the SustiNet Plan and such funding sources shall be included in the report prepared pursuant to subsection (d) of this section.

(c) The board of directors shall recommend that the public authority 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 of directors shall include in its recommendations that the public authority monitor the accomplishment of such objectives and modify action plans as necessary. The public authority's action plans and progress made with respect to achieving the objectives of such plans shall be included in the report prepared pursuant to subsection (d) of this section.

(d) On or before July 1, 2010, and annually thereafter, the board of directors shall report, in accordance with the provisions of section 11-4a of the general statutes, 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, as well as the design and implementation of the SustiNet Plan.

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) The board of directors shall recommend that the public authority: (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 of directors shall establish an information technology committee that shall formulate a plan 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.

(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 identify potential software and hardware options that meet the needs of the full array of health care practices in the state. Any electronic medical record package that the committee recommends for future possible 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) The committee shall recommend that any approved software have the capacity to: (1) Gather information pertinent to assessing health care outcomes, including activity limitations, self-reported health status and other quality of life indicators; and (2) allow the board of directors to track the accomplishment of clinical care objectives at all levels. The board of directors 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 public authority.

(f) On behalf of subscribing health care providers, the board of directors shall recommend that the public authority seek 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) The information technology committee shall recommend 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 be designed to automatically update approved software. Such updates may include incorporating newly approved clinical care guidelines, software patches or other changes.

(h) All recommendations concerning electronic medical records and electronic health records shall be developed and administered in a manner that is consistent with board of directors 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 recommended by the board of directors shall be in addition to those otherwise available under state or federal law.

(i) The committee shall develop recommended methods to eliminate or minimize transition costs for health care providers that, prior to July 1, 2010, 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.

(j) The committee shall recommend that the public authority 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 public authority shall not share in the systemic cost savings.

(k) The committee shall recommend that electronic health records be structured to facilitate the provision of medical home functions pursuant to section 6 of this act. The committee shall recommend

methods for such electronic health records to 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.

(l) The committee shall recommend that each participating provider use 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 (g) of this section. The committee shall develop and implement appropriate financial incentives for early subscriptions by participating providers, including discounted fees for providers who do not delay their subscriptions. The committee shall recommend that no later than July 1, 2015, the board of directors require as a condition of participation in the SustiNet Plan that each participating provider use 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 (g) of this section. The committee shall recommend that after July 1, 2015, the board of directors have authority to 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. The committee shall recommend that such provider be allowed to 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.

(m) The committee shall recommend methods to 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 committee 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.

Sec. 6. (NEW) (*Effective July 1, 2009*) (a) The board of directors shall establish a medical home advisory committee that shall develop recommended internal procedures for the public authority 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 of directors in accordance with such time and format requirements as may be prescribed by said board. The medical home advisory committee shall be composed of physicians, nurses, consumer representatives and other qualified individuals chosen by said board.

(b) The committee shall recommend that: (1) Medical home functions be defined by the board on an ongoing basis that incorporates evolving research concerning the delivery of health care services; and (2) if limitations in provider infrastructure prevent all SustiNet Plan members from being enrolled in patient-centered medical homes, enrollment in medical homes 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 of directors, the committee shall recommend that initial medical home functions 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) The committee shall recommend that: (1) A licensed health care provider be allowed to 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; and (2) a group practice or community health center serving as a medical home identify, for each member, a lead provider with primary responsibility for the member's care. In appropriate cases, as determined by the board of directors, 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) The committee shall recommend that: (1) Each medical home provider be presented with a listing of all medical home functions, including patient education, care coordination and twenty-four-hour accessibility; and (2) if a provider does not wish to perform, within his or her office, certain functions outside core medical home functions, such provider, with assistance from the public 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 public authority, health care insurers or other individuals or entities and shall be certified by the public 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 public 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 medical home advisory committee may develop 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 committee shall recommend that the public authority assist in the development of community-based resources to enhance medical home functions, including linguistically and culturally competent member education and care coordination.

(h) The committee shall recommend that: (1) All of the medical home functions set forth in this section be reimbursable and covered by the SustiNet Plan; (2) to the extent that such functions are generally not covered by commercial insurance, the public authority set payment levels that cover the full cost of performing such functions; and (3) in setting such payment levels, the public authority may: (A) Utilize rate-setting procedures based on those used to set physician payment levels for Medicare; (B) establish monthly case management fees paid based

on demonstrated performance of medical home functions; or (C) take other steps, as deemed necessary by the board, to make payments that cover the cost of performing each function.

(i) The committee shall recommend that specialty referrals 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 of directors 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 committee shall forward their recommended clinical care and safety guidelines to the board of directors in accordance with such time and format requirements as may be prescribed by said board. The committee shall include both health care consumers and health care providers.

(b) The committee shall recommend that health care providers participating in the SustiNet Plan 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 committee shall recommend 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. The committee shall recommend that providers who meet or exceed quality of care standards for a particular medical condition be publicly recognized by the board of directors in such manner as said 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 committee shall recommend 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. The committee shall recommend that any review conducted in accordance with the provisions of this subsection be subject to the protections afforded by section 19a-17b of the general statutes.

(e) The board of directors, in consultation with representatives from licensed hospitals, shall develop hospital safety standards that shall be implemented in such hospitals. The board of directors 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 committee shall recommend that the public authority 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 public authority, are less than optimally cost effective. The committee shall recommend that the public authority may furnish participating providers with free samples of generic or other prescription drugs.

(g) The committee shall recommend that the public authority 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 of directors 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 said 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 of directors at any time.

(b) The board of directors shall recommend that the SustiNet Plan provide coverage for community-based preventive care services and such services 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 of director approved standards for quality of care. The board of directors shall recommend that: (1) Prior to furnishing a community-based preventive care service, a provider 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; and (2) a provider 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. The board of directors shall recommend that community-based preventive services be allowed to be provided at job sites, schools or other community locations consistent with said board's guidelines.

Sec. 9. (NEW) (*Effective July 1, 2009*) (a) The board of directors shall develop recommendations that ensure that: (1) 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; (2) benefits, access to providers and out-of-pocket cost-sharing rules that apply to such members be consistent with all collective bargaining agreements that apply to such members; (3) the coalition committee established pursuant to subsection (f) of section 5-278 of the general statutes retains jurisdiction over policy and practice matters that pertain exclusively to coverage for state employees and retirees; (4) the coalition committee has authority to overrule any decision of the board of directors to the extent that such decision (A) would apply to state employees, retirees

or their dependents; and (B) 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; and (5) said board takes no action that impinges on a collective bargaining agreement applicable to state employees and retirees and that such collective bargaining agreement remains in full force and effect unless amended.

(b) The board of directors shall develop recommendations to ensure that HUSKY Plan Part A and Part B beneficiaries enroll in the SustiNet Plan.

(c) The board of directors shall make recommendations to ensure that on and after October 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.

(d) The board of directors shall make recommendations 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 recommendations shall include that, 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 exceeds 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 of directors. Said board shall also make recommendations for the establishment of a simplified

enrollment procedure for those individuals who demonstrate eligibility to enroll in the SustiNet Plan pursuant to this subsection.

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 board of directors shall recommend that: (1) The public authority be authorized to use new and existing channels of sale to employers, including public and private purchasing pools, agents and brokers; (2) the public authority be authorized to offer multi-year contracts to employers, offering predictable premiums; (3) policies and procedures be established to ensure that employers can easily and conveniently purchase SustiNet Plan coverage for their workers and dependents, including, but not limited to, participation requirements, timing of enrollment, open enrollment, enrollment length and other subject matters as deemed appropriate by said board; (4) policies and procedures be established to prevent adverse selection and achieve other goals specified by the board; (5) beginning on July 1, 2011, small employers be allowed to purchase SustiNet Plan coverage and that the public authority be allowed to 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; (6) beginning on July 1, 2015, employers that are not small employers be allowed to purchase SustiNet Plan coverage and the public authority be allowed to 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 of directors; and (7) employers purchasing coverage under this section be offered the standard benefits package, provided no such benefit package provide less comprehensive coverage than that described in the model benefits packages adopted pursuant to section 14 of this act.

Sec. 11. (NEW) (*Effective July 1, 2009*) (a) As used in this section, "clearinghouse" means an independent information clearinghouse recommended by the board of directors 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 of directors.

(c) The board of directors shall recommend that 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, 2011*) (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, 2012, all adults with incomes at or below one hundred eighty-five per cent of the federal poverty level are eligible for enrollment in the HUSKY Plan, Part A, 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, 2012, 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.

Sec. 13. (NEW) (*Effective July 1, 2009*) Notwithstanding any provision of the general statutes, on an 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. 14. (NEW) (*Effective July 1, 2009*) (a) Within available appropriations, the Office of the 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 the Healthcare Advocate shall report, in accordance with the provisions of section 11-4a of the general statutes, to 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 updated model benefit packages.

(b) After the promulgation of the model benefit packages, as provided in subsection (a) of this section, the board of directors may modify the standard benefits package if said 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 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. 15. (NEW) (*Effective July 1, 2009*) (a) The board of directors shall develop recommendations for 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) The 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. 16. (NEW) (*Effective July 1, 2009*) The board of directors, in collaboration with state and municipal agencies, shall, within available appropriations, develop and implement systematic recommendations to identify uninsured individuals in the state. Such recommendations may include that:

(1) The Department of Revenue Services modify state income tax forms to request that a taxpayer identify existing health coverage for each member of the taxpayer's household.

(2) The Labor Department 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.

(3) Hospitals, community health centers and other providers as

determined by the board of directors shall: (A) Identify uninsured individuals who seek health care, and (B) convey such information, via secure electronic mail transmission, to said board and the Department of Social Services to facilitate the potential enrollment of such individuals into health insurance coverage.

Sec. 17. 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, 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**]** the 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. 18. (*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. 19. (*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. 20. (*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, 2011*	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, 2011*	17b-297b
Sec. 18	*from passage*	New section
Sec. 19	*from passage*	New section
Sec. 20	*from passage*	New section

INS *Joint Favorable Subst.*

OFA Fiscal Note

State Impact: See Below

Municipal Impact: See Below

Explanation

SustiNet Board

This bill establishes the SustiNet Health Partnership board of directors. The purpose of the Partnership is to design and establish the Sustinet Plan, which is intended to provide health care coverage in the state. The Partnership, by law as proposed in this bill, is not to be construed as a department, institution, or agency of the state. The Partnership is required to submit a range of recommendations to the General Assembly concerning the implementation of the Sustinet Plan, including the creation of an agency having the power to operate as a quasi-public authority. These recommendations must be submitted as proposed legislation to the General Assembly by January 1, 2011. The Partnership is also required to establish several committees that are required to make recommendations in a variety of health care policy areas.

The bill establishes the Sustinet Health Partnership board of directors as a voluntary organization that is not a state agency and receives no appropriated funds. State agencies that are involved with the Board will incur minimal administrative expenses related to Board activities. Any potential costs associated with this organization would involve the implementation of the recommendations made to the legislature as outlined in the bill. However, as those recommendations are subject to approval by the legislature, any costs associated with them would be related to the implementation of that

subsequent legislation.

Public Assistance Programs

The bill 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, on or after July 1, 2012.

This programmatic expansion would increase quantifiable gross state costs by at least $530 million 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.

- **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. Fully enrolling these uninsured individuals in HUSKY would cost approximately $480 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 $480 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 $440 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 rates currently 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.

- **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.

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 Advocate.

Task Forces

The bill establishes three task forces to study obesity, tobacco use, and shortages in medical personnel. Any state agencies that are involved with these task forces will incur minimal administrative expenses related to task force activities.

Sources: *Department of Social Services Caseload Information*
Office of the State Comptroller
United States Census Bureau

OLR Bill Analysis

sHB 6600

AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

SUMMARY:

This bill establishes a 14-member SustiNet Health Partnership Board of Directors that must make legislative recommendations, by January 1, 2011, on the details and implementation of the "SustiNet Plan," a self-insured health care delivery plan administered by a public authority and intended to extend insurance coverage to the state's uninsured population. The bill specifies that these recommendations must include:

1. establishment of a public authority with the power to contract with insurers and health care providers, develop health care infrastructure ("medical homes"), set reimbursement rates, create advisory committees, and encourage the use of health information technology;

2. provisions for the phased-in offering of the SustiNet Plan to state employees and retirees, HUSKY A and B beneficiaries, people without employer-sponsored insurance (ESI), people with unaffordable ESI, and small and large employers ;

3. guidelines for development of a model benefits package; and

4. public outreach and methods of identifying uninsured citizens.

The board must also establish a number of separate committees to address and make recommendations concerning health information technology, medical homes, clinical care and safety guidelines, and preventive care and improved health outcomes. The bill also

establishes an independent information clearinghouse to provide employers, consumers, and the general public with information about SustiNet and private health care plans.

The bill expands eligibility for adults under HUSKY A and B beginning July 1, 2012.

Finally, the bill 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 (§ 17) and Medicaid and HUSKY eligibility expansion (§ 12) take effect July 1, 2011, and the three task forces (§§ 18-20) take effect upon passage.

§ 1 — DEFINITIONS

The bill defines the "SustiNet Plan" as a self-insured health care delivery plan, administered by the public authority and operated by a public-private partnership that is designed to ensure that is enrollees receive high-quality health care coverage without unnecessary costs. "Public authority" means the public authority recommended by the SustiNet Health Partnership board of directors (see § 2).

"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.

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.

§ 2 — ESTABLISHING THE SUSTINET HEALTH PARTNERSHIP BOARD OF DIRECTORS

Board Members

The bill establishes the SustiNet Health Partnership board of directors consisting of 14 members as follows:

1. the state comptroller or her designee;
2. the healthcare advocate or his designee;
3. a representative of an employer-based association, appointed by the governor;
4. a representative of an employer with 50 or fewer employees, appointed by the lieutenant governor;
5. an expert in health care delivery and a person experienced in health information technology, both appointed by the Senate president pro tempore;
6. a representative of Medicaid and Husky plan beneficiaries, and a representative of a nonprofit health advocacy association, appointed by the House speaker;
7. a representative of the Connecticut Hospital Association, appointed by the Senate majority leader;
8. a representative of the Connecticut State Medical Society,

appointed by the House majority leader;

9. a representative of the Connecticut Nurses Association, appointed by the Senate minority leader;

10. a representative of private employers, appointed by the House minority leader; and

11. a representative of labor unions and a representative of business management, both appointed by the State Employee Bargaining Agent Coalition.

The commissioners of the departments of Social Services (DSS), Public Health (DPH), Mental Health and Addiction Services (DMHAS), and Insurance (DOI), are ex-officio, non-voting board members. The comptroller and healthcare advocate serve as board chairpersons.

Initial appointments must be made by July 15, 2009. If an appointing authority fails to appoint a member by that time, the Senate president pro tempore and the House speaker jointly make that appointment. A quorum is seven members.

Board members' terms are staggered. The initial term for members appointed by the governor, lieutenant governor, and Senate president pro tempore is two years. For those appointed by the House speaker and Senate majority leader, the term is three years. For the House majority leader and Senate minority leader appointments, the term is four years. And the term is five years for the initial appointment of the House minority leader. After the initial term, board members serve five-year terms.

Within the 30 days before a term expires, the appointing authority can reappoint a current member or appoint a new one. Board members can be removed by their appointing authority for misfeasance, malfeasance or willful neglect of duty.

The bill specifies that the board is not a department, institution, or

agency of the state.

§ 3 — DUTIES OF THE SUSTINET BOARD OF DIRECTORS

Designing the Sustinet Plan

The SustiNet Health Partnership board of directors must design and establish procedures to implement the "SustiNet Plan," a self-insured health care delivery plan. The SustiNet Plan must 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.

By January 1, 2011, the board must submit its design and implementation procedures in recommended legislation to the Appropriations and the Finance, Revenue, and Bonding committees.

Designing the Public Authority

The board must offer recommendations (the bill does not state to whom the recommendations go) on the establishment of a public authority authorized 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;

19. raise funds from public and private sources outside of the state budget to contribute toward support of its mission and operations;

20. make optimum use of opportunities created by the federal government for securing new and increased federal funding, including increased reimbursement revenues;

21. submit preliminary recommendations for the implementation of the SustiNet Plan to the General Assembly, not later than 60 days after the date of federal health care reform enactment; and

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

§ 4 — SUSTINET PLAN

The board of directors 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 recommend (the bill does not specify to whom the recommendations go) that the authority establish 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 include recommendations that the authority monitor the progress made toward achieving these objectives and modify the action plans as necessary. It must identify all potential funding sources that will be used to establish and administer the SustiNet Plan. It must annually report to the legislature, beginning July 1, 2010, on (1) the authority's action plans and progress toward meeting these objectives, (2) the status of health care in the state, and (3) the design and implementation of the SustiNet Plan. (But as noted in § 3 above, the bill requires the board to submit its design and implementation procedures by January 1, 2011.)

§§ 1 AND 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 multiple health care organizations;

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 health care technology goods and services, 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 Development

The board must establish an information technology committee to make a plan 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. The committee must recommend methods to coordinate the development and implementation of electronic health and medical records with DPH, Office of Health Care Access (OHCA), and other state agencies to ensure "efficiency and compatibility." The committee must determine appropriate financing options, including financing through the Connecticut Health and Educational Facilities Authority.

Software and Hardware Options and Availability

The board must recommend that the public authority (1) provide approved software to subscribing providers and participating providers (the bill does not define this term), 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 identify potential

software and hardware options that meet the needs of the full array of health care practices. Any recommended electronic medical records packages the committee recommends for possible purchase must interact with other pertinent practice management modules including patient scheduling, claims submission, billing, and tracking of laboratory orders and prescriptions.

Any recommended system must also include:

1. automated patient reminders concerning upcoming appointments;

2. recommended preventive care reminders;

3. automated provision of test results to patients when appropriate;

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

5. notice of potentially duplicative tests and other services;

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.

The committee must recommend that any approved software be able to gather information to help the board assess health outcomes and track the accomplishment of clinical care objectives. The board must ensure that SustiNet Plan providers who use approved software can 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.

The board, on behalf of subscribing providers, must recommend that the public authority seek vendors to provide reduced-cost, high-quality digitization of paper medical records for use with approved software. The vendors must be bonded, supervised and covered entities under the federal Health Insurance Portability and Accountability Act, that is, subject to the act's privacy requirements.

System Integration

The information technology committee must recommend 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 all recommendations on electronic health and medical records to be developed in a manner consistent with board approved guidelines for safeguarding privacy and data security, which include recommended remedies and sanctions in cases where guidelines are not followed.

Condition of Participation in SustiNet

Under the bill, the committee must recommend that use of electronic medical records become 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 cannot meet the timeframe and whose participation in SustiNet is necessary to assure geographic access to care. It authorizes the board to provide additional support to these providers. (But it is not clear what kind of support the board can provide.)

The bill includes specific incentives to help providers meet the goal of adoption of electronic medical records by July 1, 2015. The committee must develop and implement appropriate financial incentives for early subscriptions by participating providers, including discounted fees.

The committee must develop recommended methods to eliminate or minimize transition costs for providers, who, before July 1, 2010, implemented comprehensive electronic medical or health records systems. This can include technical assistance in transitioning to new software and development of modules to help existing software connect to the integration system.

The committee must recommend that the public authority share with subscribing providers systemic cost savings achieved by implementing electronic medical and health records. The amount of savings the board shares with a provider is limited to the amount of net financial loss the provider experienced during the first five years of the implementation process.

The committee must also recommend that the structure of electronic health records encourage the provision of medical home functions (see below). Electronic health records must 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, and (3) identify the expiration of refillable prescriptions.

§ 6 — MEDICAL HOMES

Medical Home Advisory Committee

The board must establish a medical home advisory committee composed of physicians, nurses, consumer representatives, and other qualified individuals chosen by the board. The committee must develop procedures for the authority and proposed regulations for the operation of medical homes providing services to SustiNet Plan members. (It is not clear what agency would promulgate these regulations.) The committee must forward its recommendations to the board.

Medical Home Functions

The committee must recommend that the board define medical home functions on an ongoing basis, incorporating evolving research

on delivery of health care services. It must recommend that 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.

The committee, subject to revision by the board, must recommend that the 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, and tobacco use, 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, and 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 committee must recommend that the public authority assist in developing community-based resources to enhance medical home functions, including linguistically and culturally competent member education and care coordination.

Health Care Providers Who Can Serve as a Medical Home

Under the bill, the committee must recommend that (1) 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 and (2) 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.

The committee must recommend that each medical home provider be given a list of all medical home functions, including patient education, care coordination, and 24-hour accessibility. It must recommend that if a provider does not wish to perform certain functions outside core medical home functions in his or her office, 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. 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. At the medical home provider's request, 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 not assume.

Reimbursement

The committee must recommend that all of the medical home functions are reimbursable under the SustiNet Plan. The committee must recommend that in setting payment levels for those functions that are not normally reimbursed by commercial insurers, the authority may use different possible rate-setting mechanisms, including using Medicare rate-setting methods or setting a monthly case management fee.

The committee's recommendations must include a requirement that the medical home provider discuss possible referral with the specialist to determine if it is medically indicated and if so, what tests should be done in advance. The bill requires the SustiNet Plan to reimburse providers for this consultation.

§ 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, the committee must recommend that participating SustiNet providers receive confidential reports comparing their practice patterns with their peers. The report must include opportunities for continuing education.

The committee must recommend 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. The committee must recommend that providers who meet or exceed the standards for a particular condition be publicly recognized and made known to SustiNet members, including those who have been diagnosed with that particular medical condition.

The committee must recommend procedures requiring hospitals and their staffs, physicians, nurse practitioners, and other participating providers to periodically conduct quality of care reviews and develop quality of care improvement plans. Such reviews must identify 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 be subject to the law's protections concerning peer review (CGS § 19a-17b).

The board, in consultation with hospital representatives, must develop safety standards for implementation in these hospitals. The board 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. (It is not clear whether the board enforces these sanctions and provides the incentives if it is to recommend these for the public authority.)

The committee must recommend that the authority 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 authority judges are less than

optimally cost effective. The committee must recommend that the public authority may give participating providers free samples of generic or other prescription drugs. And the committee must recommend that the authority 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 of directors to establish a preventive health care committee to make recommendations to improve health outcomes for members (presumably SustiNet 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 board must recommend that the SustiNet plans sold to employers or individuals 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. The board must recommend that community-based preventive care providers must use the patient's electronic health record to confirm that the service is needed and is not contraindicated. 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 and Retirees

The board must develop recommendations that ensure that, beginning July 1, 2011, SustiNet 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. SEBAC 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 or quality of care, or increase enrollee costs when compared to "governing laws" in effect on January 1, 2009.

HUSKY PLAN Part A and B Beneficiaries

The board must develop recommendations to ensure that HUSKY Plan Part A and Part B beneficiaries enroll in SustiNet.

Those Not Offered Employee Sponsored Insurance (ESI)

The bill requires the board to make recommendations to ensure that people not offered employer sponsored insurance **(**ESI**)** and who do not qualify for Medicare can enroll in SustiNet beginning October 1, 2011.

Those Offered Unaffordable or Inadequate ESI

The board must make recommendations to provide an option for enrollment in SustiNet to certain state residents who are offered ESI. 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 ESI premiums is 2% or more of household income above what the individual would pay to enroll 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 make recommendations for

establishing a simplified enrollment procedure for those individuals who can enroll in the SustiNet plan under these provisions.

§ 10 — OFFERING SUSTINET TO EMPLOYERS THROUGH EXISTING CHANNELS

The bill requires the board to recommend that the authority (1) use various ways to sell SustiNet to employers, including public and private purchasing pools, agents, and brokers and (2) be able to offer multi-year contracts that have predictable premiums. The board must recommend 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 recommend 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.

The board must recommend that (1) small employers (up to 50 employees) can purchase SustiNet beginning on July 1, 2011 and (2) the authority be allowed to use small group rating rules for setting premiums.

The board must recommend that larger employers can begin offering SustiNet on July 1, 2015. Further, to prevent adverse selection, it must recommend that the authority 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.

The board must recommend that all employers be offered a standard benefits package that cannot be any less comprehensive than the model benefits packages established by the bill (see§ 14).

§ 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 bill charges OHA with developing such specifications, in consulatation with the board and private insurers.

The board must recommend that 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 — EXPANSION OF MEDICAID AND HUSKY ELIGIBILITY

The bill directs the DSS commissioner, to the extent allowed by federal law, to take all necessary steps to ensure that beginning July 1, 2012, 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 between 186% and 300% FPL eligible for HUSKY B beginning July 1,

2012, to the extent permitted by federal law. 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.

§ 13 — 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. That is, premiums may not be based on medical underwriting and 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).

§ 14 — VALUE-BASED BENEFITS DESIGN

The bill requires OHA, within available appropriations, 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 board may modify 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, OHA must report on these guidelines and recommendations to the governor, comptroller, and the Public Health, Labor and Public Employees, and Appropriations Committees.

§ 15 — PUBLIC EDUCATION AND OUTREACH CAMPAIGNS

The bill requires the board to develop recommendations for public education and outreach campaigns to inform the public of SustiNet's availability and encourage enrollment. These campaigns must use community-based organizations to reach underserved populations. They must be based on evidence of the cost and effectiveness of similar efforts in this state and elsewhere. The board must continuously evaluate their effectiveness, and change strategy as needed.

§ 16 — AUTOMATIC ENROLLMENT

The board, in collaboration with state and municipal agencies, must, within available appropriations (the bill does not appropriate any funds for the board), develop and implement recommendations to identify uninsured individuals. Such recommendations may include:

1. the Department of Revenue Services modifying state income tax forms to ask taxpayers to identify existing health coverage for each household member;

2. the Department of Labor (DOL) modifying its unemployment insurance claims forms to request information about health insurance status for applicants and their dependents; and

3. hospitals, community health centers, and other health care providers to identify uninsured individuals who seek health care, and transmit such information to the board and DSS.

§ 17 — IDENTIFYING UNINSURED CHILDREN

The bill directs the DSS and education commissioners to consult with the board in their existing obligation to jointly establish

procedures for sharing data from the National School Lunch Program to identify income eligible children for enrollment in or HUSKY A and B. And it permits their procedures to cover enrollment in the SustiNet Plan.

§ 18 — 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.

§ 19 — 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.

§ 20 — 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.

BACKGROUND

Legislative History

The House referred the bill (File 615) to the Insurance and Real Estate Committee on May 5. That committee reported out a substitute bill on May 6 that makes numerous changes to the original file. The substitute creates the 14-member SustiNet Health Partnership Board of Directors instead of a nine-member SustiNet Authority. It also directs the board to make legislative recommendations on the design and implementation of the SustiNet Plan, rather than providing those details as in the original file. The substitute eliminates a number of provisions in the original bill including the creation of a "SustiNet Account," a "shared responsibility" requirement for certain employers and employees involving payments to the account, automatic enrollment, eligibility redetermination, evaluation of outcomes and policy changes, reporting requirements, indemnification of SustiNet Authority personnel and officers, and certain definitions.

COMMITTEE ACTION

Public Health Committee

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

Human Services Committee

Joint Favorable
Yea 13 Nay 6 (04/22/2009)

Labor and Public Employees Committee

Joint Favorable
Yea 8 Nay 3 (04/29/2009)

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 13 Nay 4 (05/06/2009)