House of Representatives

File No. 996

General Assembly

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Substitute House Bill No. 6600
As Amended by House Amendment
Schedules "A" and "B"

Approved by the Legislative Commissioner
May 21, 2009

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 14, 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, that is designed to ensure that plan members receive high-quality health care coverage without unnecessary costs;

(2) "Standard benefits package" means a set of covered benefits as determined by the public authority, with out-of-pocket cost-sharing limits and provider network rules, subject to the same coverage mandates described in chapter 700c of the general statutes and the utilization review requirements described in chapter 698a of the general statutes that apply to group health insurance sold in this state. The standard benefits package includes, but is not limited to, 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 convincing scientific evidence demonstrates that such programs are effective in reducing the severity or incidence of chronic disease;

(B) A per individual and per family deductible, 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;

(E) Prescription drug coverage with copayments 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, consideration shall be given to 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 a public authority or other entity recommended by the SustiNet Health Partnership board of directors in accordance with the provisions of subsection (b) of section 3 of this act;

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

(9) "Nonstate public employer" means a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library.

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 nine members, as follows: The Comptroller; the Healthcare Advocate; one appointed by the Governor, who shall be a representative of the nursing or allied health professions; one appointed by the president pro tempore of the Senate, who shall be a primary care physician; one appointed by the speaker of the House of Representatives, who shall be a representative of organized labor; one appointed by the majority leader of the Senate, who shall have expertise in the provision of employee health benefit plans for small businesses; one appointed by the majority leader of the House of

Representatives, who shall have expertise in health care economics or health care policy; one appointed by the minority leader of the Senate, who shall have expertise in health information technology; and one appointed by the minority leader of the House of Representatives, who shall have expertise in the actuarial sciences or insurance underwriting. The Comptroller and the Healthcare Advocate 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 31, 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 five members shall constitute a quorum for the transaction of business. The initial term for the board member appointed by the Governor shall be for two years. The initial term for board members appointed by the minority leader of the House of Representatives and the minority 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 majority leader of the Senate shall be for four years. The initial term for the board members appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall be for five years. Terms pursuant to this subdivision shall expire on June thirtieth in accordance with the provisions of this subdivision. Any vacancy shall be filled by the appointing authority for the balance of the unexpired term. 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. The staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall provide administrative support to the board of directors.

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; (5) slow the growth of per capita health care spending both in the short-term and in the long-term; and (6) implement reforms to the health care delivery system that will apply to all SustiNet Plan members, provided any such reforms to health care coverage provided to state employees, retirees and their dependents shall be subject to applicable collective bargaining agreements.

(b) The SustiNet Health Partnership board of directors shall offer recommendations to the General Assembly on the governance structure of the entity that is best suited to provide oversight and implementation of the SustiNet Plan. Such recommendations may include, but need not be limited to, the establishment of a public authority authorized and empowered:

(1) To adopt guidelines, policies and regulations in accordance with chapter 54 of the general statutes that are necessary to implement the provisions of sections 1 to 14, inclusive, of this act;

(2) 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 or other entities may take into account their capacity and willingness to (A) offer timely 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;

(3) 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 access to timely, high-quality care throughout the state and, in appropriate cases, care that is outside the state's borders;

(4) To establish appropriate deductibles, standard 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;

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

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

(7) 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;

(8) 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;

(9) To enter into interagency agreements for performance of SustiNet Plan duties that may be implemented more efficiently or effectively by an existing state agency;

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

(11) 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;

(12) 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;

(13) To evaluate the implementation of an individual mandate in concert with guaranteed issue, the elimination of preexisting condition exclusions, and the implementation of auto-enrollment;

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

(15) 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;

(16) 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

(17) To study the feasibility of funding premium subsidies for individuals with income that exceeds three hundred per cent of the federal poverty level but does not exceed four hundred per cent of the federal poverty level.

(c) 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.

(d) All state and municipal agencies, departments, boards, commissions and councils shall fully cooperate with the board of directors 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.

(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.

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 establish an information technology advisory 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. The committee shall offer recommendations on matters that include, but are not limited to: (1) The furnishing of 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) the development and implementation of 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 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.

(d) The committee shall offer recommendations on the procurement and development of approved software. Such recommendations may include 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.

(e) The committee shall offer recommendations on the selection of 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.

(f) The committee shall offer recommendations on 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.

(g) All recommendations concerning electronic medical records and electronic health records shall be developed and administered in a manner that is consistent with guidelines approved by the board of directors for safeguarding privacy and data security and with state and federal law, including any 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.

(h) The committee shall develop recommended methods to

eliminate or minimize transition costs for health care providers that, prior to January 1, 2011, have 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.

(i) The committee shall offer recommendations that permit subscribing providers to receive a 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.

(j) The committee shall offer recommendations concerning the use of electronic health records to facilitate the provision of medical home functions as described in 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.

(k) The committee shall offer recommendations requiring: (1) 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 (f) of this section; (2) the development and implementation of appropriate financial incentives for early subscriptions by participating providers, including discounted fees for providers who do not delay their subscriptions; (3) 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 (f) of this section; (4) 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; and (5) 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 access to care.

(l) 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 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 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) Committee recommendations concerning patient-centered medical homes shall include that: (1) Medical home functions be defined by the board of directors 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 offer recommendations 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 offer recommendations on entities that may serve as a medical home, including 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 offer recommendations concerning the responsibilities of a medical home provider. Such recommendations shall include 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 shall 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 shall be certified by the board of directors based on factors that include the quality, safety and efficiency of the services provided. At the request of a core medical home provider, the board of directors 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, but not limited to:

(1) The availability of 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;

(2) 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; and

(3) 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 the delivery of linguistically and culturally competent health care services.

(h) The committee shall offer recommendations concerning payment for medical home functions, including 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, payment levels cover the full cost of performing such functions; and (3) in setting such payment levels, consideration be given to: (A) Utilizing rate-setting procedures based on those used to set physician payment levels for Medicare; (B) establishing monthly case management fees paid based on demonstrated performance of medical home functions; or (C) taking other steps, as deemed necessary by the board of directors, to make payments that cover the cost of performing each function.

(i) The committee shall offer recommendations 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 advisory 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 offer recommendations 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 offer recommendations concerning 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 offer recommendations 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's recommendations shall include 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 the committee, 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 offer recommendations pertaining to information to be made available to participating providers concerning 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 offer recommendations concerning the provision of free samples of generic or other prescription drugs to participating providers.

(g) The committee shall recommend policies and procedures 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 advisory 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 preventive health care advisory committee shall submit such recommendations to the board of directors.

(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 may develop recommendations that ensure that on and after July 1, 2012, nonstate public employers are offered the benefits of the SustiNet Plan. The board of directors may develop recommendations that permit the Comptroller to offer the benefits of the SustiNet Plan to state employees, retirees and their dependents. No changes in health care benefits shall be implemented with regard to plans administered under the provisions of subsection (a) of section 5-259 of the general statutes unless such changes are negotiated and agreed to by the state and the coalition committee established pursuant to subsection (f) of section 5-278 of the general statutes, through the collective bargaining

process.

(b) The board of directors shall develop recommendations that ensure that on and after July 1, 2012, employees of nonprofit organizations and small businesses are offered the benefits of the SustiNet Plan.

(c) The board of directors shall develop recommendations to ensure that the HUSKY Plan Part A and Part B, Medicaid, and state-administered general assistance programs participate in the SustiNet Plan. Such recommendations shall also ensure that HUSKY Plan Part A and Part B benefits are extended, to the extent permitted by federal law, to adults with income at or below three hundred per cent of the federal poverty level.

(d) The board of directors shall make recommendations to ensure that on and after July 1, 2012, state residents who are not offered employer-sponsored insurance and who do not qualify for HUSKY Plan Part A and Part B, Medicaid, or state-administered general assistance are permitted to enroll in the SustiNet Plan. Such recommendations shall ensure that premium variation based on member characteristics does not exceed in total amount or in consideration of individual health risk, the variation permitted for a small employer carrier, as defined in subdivision (16) of section 38a-564 of the general statutes.

(e) 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 but who have a household income at or below four hundred per cent of the federal poverty level. Said board may make recommendations for the establishment of (1) an enrollment procedure for those individuals who demonstrate eligibility to enroll in the SustiNet Plan pursuant to this subsection; and (2) a method for the collection of payments from employers, whose employees would have received employer-sponsored insurance, but instead enroll in the

SustiNet Plan in accordance with the provisions of 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 members.

(b) The board of directors shall offer recommendations concerning: (1) The use of new and existing channels of sale to employers, including public and private purchasing pools, agents and brokers; (2) the offering of multi-year contracts to employers with predictable premiums; (3) policies and procedures to be established that 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 to be established that prevent adverse selection and achieve other goals specified by the board; (5) the availability of SustiNet Plan coverage for small employers on and after July 1, 2012, with premiums based on member characteristics as permitted for small employer carriers, as defined in subdivision (16) of section 38a-564 of the general statutes; (6) the availability of SustiNet Plan coverage for employers who are not small employers with 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) the availability of a standard benefits package to employers purchasing coverage under this section, provided no such benefit package provide less comprehensive coverage than that described in the model benefits packages adopted pursuant to section 12 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 licensed in the state of Connecticut.

(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, 2013, with updated information provided each August first thereafter.

Sec. 12. (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 member 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 to the board of directors 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 member populations may reduce net costs or provide sufficient improvements to health outcomes to warrant the resulting increase in net costs. Any such modification of the standard benefits package by the board shall ensure compliance with the coverage mandates described in chapter 700c of the general statutes and the utilization review requirements described in chapter 698a of the general statutes.

(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, 2012, 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 board of directors, the Governor 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. 13. (NEW) (*Effective July 1, 2011*) (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. 14. (NEW) (*Effective July 1, 2011*) 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 the health insurance status of individuals who seek health care, and (B) convey such information, via secure electronic mail transmission, to said board to facilitate the potential enrollment of such individuals into health insurance coverage.

Sec. 15. 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. 16. (*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 board of directors and 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. 17. (*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 board of directors and 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. 18. (*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, including, physicians, nurses and allied health professionals.

(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 primary care physician;

(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 board of directors and 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. (NEW) (*Effective July 1, 2009*) Any individual who serves on the SustiNet Health Partnership board of directors shall be subject to the provisions of section 1-83 of the general statutes concerning the

968 filing of a statement of financial interests.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	New section
Sec. 2	*July 1, 2009*	New section
Sec. 3	*July 1, 2009*	New section
Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	New section
Sec. 6	*July 1, 2009*	New section
Sec. 7	*July 1, 2009*	New section
Sec. 8	*July 1, 2009*	New section
Sec. 9	*July 1, 2009*	New section
Sec. 10	*July 1, 2009*	New section
Sec. 11	*July 1, 2009*	New section
Sec. 12	*July 1, 2009*	New section
Sec. 13	*July 1, 2011*	New section
Sec. 14	*July 1, 2011*	New section
Sec. 15	*July 1, 2011*	17b-297b
Sec. 16	*from passage*	New section
Sec. 17	*from passage*	New section
Sec. 18	*from passage*	New section
Sec. 19	*July 1, 2009*	New section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: See Below

Municipal Impact: See Below

Explanation

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, 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 additional 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.

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

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.

House "A" struck the underlying bill and replaced it with the impact noted above. This eliminated a significant cost associated with an expansion of eligibility under the Department of Social Services' HUSKY programs.

House "B" made individuals who serve on the SustiNet board subject to provisions concerning filing statements of financial interests. It had no associated fiscal impact.

OLR Bill Analysis

sHB 6600 (as amended by House "A" and "B")*

AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

SUMMARY:

This bill establishes a nine-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. The bill specifies that these recommendations must address:

1. establishment of a public authority or other entity 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, small and large employers, and others ;

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

4. public outreach and methods of identifying uninsured citizens.

The board must 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.

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

*House Amendment "A" (1) reduces the board membership from 14 to nine members and changes board representation and corresponding appointing authorities; (2) specifies that the board must offer recommendations to the General Assembly on the governance structure of an entity to oversee and implement the SustiNet Plan which may include establishing a public authority, rather than directing the board to make recommendations on establishing a public authority; (3) makes changes to the list of recommendations that the board may offer, including adding (a) evaluating the implementation of an individual mandate in concert with guaranteed issue, elimination of preexisting condition exclusions, and implementation of auto-enrollment and (b) studying the feasibility of funding premium subsidies for individuals with income between 300% and 400% of the federal poverty level; (4) requires the board to identify all potential funding sources for establishing and administering SustiNet; (5) specifies that the board may develop recommendations (a) permitting the comptroller to offer the SustiNet Plan to state employees, retirees and their dependents, with any changes to health care benefits subject to the collective bargaining process and (b) ensuring that nonstate public employers are offered the SustiNet Plan; (6) makes changes concerning recommendations for offering SustiNet to those not offered ESI and those offered unaffordable or inadequate ESI; (7) makes changes to provisions of the bill on offering SustiNet to employers through existing channels; (8) eliminates a section on expansion of Medicaid and HUSKY eligibility; and (9) makes technical changes.

*House Amendment "B" adds the provision subjecting board members to the law on filing statements of financial interests.

EFFECTIVE DATE: July 1, 2009, except that the sections on

identifying uninsured adults and children (§ 14, 15) and Medicaid and public education outreach (§ 13) take effect July 1, 2011, and the three task forces (§§ 16-18) take effect upon passage.

§ 1 — DEFINITIONS

The bill defines the "SustiNet Plan" as a self-insured health care delivery plan designed to ensure that its enrollees receive high-quality health care coverage without unnecessary costs. "Public authority" means a public authority or other entity recommended by the SustiNet Health Partnership board of directors.

"Standard benefits package" means a set of covered benefits, as determined by the public authority, 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, but is not limited to (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 and preventive care; (3) preventive care with no copayment; (4) prescription drug coverage with copayments; (5) office visits for other than preventive care with copayments; (6) mental and behavioral health services coverage, including tobacco cessation, substance abuse treatment, and obesity prevention and treatment (these services must have parity with coverage for physical health services); and (7) dental coverage comparable to that provided by large employers in the Northeast.

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 —THE SUSTINET HEALTH PARTNERSHIP BOARD OF DIRECTORS

Board Members

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

1. the state comptroller;
2. the healthcare advocate;
3. a representative of the nursing or allied health professions, appointed by the governor;
4. a primary care physician, appointed by the Senate president pro tempore;
5. a representative of organized labor, appointed by the House speaker;
6. an individual with expertise in the provision of employee health benefit plans for small businesses, appointed by the Senate majority leader;
7. an individual with expertise in health economics or policy, appointed by the House majority leader;
8. an individual with expertise in health information technology, appointed by the Senate minority leader; and
9. an individual with expertise in actuarial sciences or insurance underwriting, appointed by the House minority leader.

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 July 31, 2009, the Senate

president pro tempore and the House speaker jointly make that appointment. A quorum is five members.

Board members' terms are staggered. The initial term for the member appointed by the governor is two years. For those appointed by the House and Senate majority leaders, the term is four years. For the House and Senate minority leaders' appointments, the term is three years. And the term is five years for the appointments of the House speaker and Senate president pro tempore. 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 any individual serving on the board is subject to existing law on filing a statement of financial interests.

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." 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; and

6. implement reforms to the health care delivery system that will apply to all SustiNet Plan members. But provided any reforms to health care coverage provided to state employees, retirees, and their dependents must be subject to applicable collective bargaining agreements.

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 to the General Assembly on the governance structure of the entity that is best suited to oversee and implement the SustiNet Plan. These recommendations may include, but are not limited to, the establishment of a public authority authorized to:

1. adopt guidelines, policies and regulations necessary to implement the bill's provisions;

2. 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 the 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;

3. solicit bids from individual providers and provider organizations to insure adequate provider networks and provide all SustiNet Plan members with timely access to high-quality care throughout the state and, in appropriate cases,

outside the state;

4. establish appropriate deductibles, standard 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;

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

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

7. 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;

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

9. enter into interagency agreements for performance of SustiNet Plan duties that may be implemented more efficiently or effectively by a state agency;

10. set payment methods for licensed health care 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;

11. 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;

12. 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 either deems relevant in educating the public about the SustiNet Plan;

13. evaluate the implementation of an individual mandate in concert with guaranteed issue, the elimination of preexisting condition exclusions,, and the implementation of auto-enrollment;

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

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

16. if the federal government enacts national health care reform, submit preliminary recommendations for implementing the SustiNet Plan to the General Assembly, not later than 60 days after federal enactment; and

17. study the feasibility of funding premium subsidies for individuals with income between 300% and 400% of the federal poverty level (FPL).

The bill specifies that all state and municipal agencies, departments, boards, commissions and councils must fully cooperate with the board in carrying out these purposes.

§ 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 identify all potential funding sources that may be used to establish and administer the SustiNet Plan.

The board must recommend that the public 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.

§§ 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 periodic payment system that allows subscribing providers to acquire approved software and hardware and to receive other support services for the implementation of electronic medical records.

Software and Hardware Options and Availability

The committee must make recommendations on (1) providing 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) developing and implementing 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, physicians, nurses, hospitals and other 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 make recommendations on procuring and

developing approved software. These recommendations may include 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 committee must make recommendations on selection of public 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 make recommendations on 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 and with state and federal laws, including any recommendations of the U.S. Government Accountability Office. These guidelines must include recommended remedies and sanctions in cases where guidelines are not followed. The remedies can include termination from the network or reimbursement denial or reduction.

The committee must recommend methods to coordinate the development and implementation of electronic medical health records in concert with the Department of Public Health (DPH) 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.

Condition of Participation in SustiNet

Under the bill, the committee must recommend that use of board-approved or compatible 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 providers who would face hardship in meeting the time frame 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 January 1, 2011, 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 integrated system.

The committee must make recommendations that subscribing providers share 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 make recommendations on the use of electronic health records to 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 recommended internal procedures and proposed regulations for the administration of medical homes serving to SustiNet Plan members. The committee must forward its recommendations to the board.

Medical Home Functions

Committee recommendations must include that (1) the board define medical home functions on an ongoing basis, incorporating evolving research on delivery of health care services and (2) if provider infrastructure limits prevent all SustiNet Plan members from enrolling in a medical home, then enrollment 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 make recommendations that initial medical home functions 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 can 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. 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 more help;

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 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.

The committee must recommend to the board that the public authority assist in developing community-based resources to enhance medical home functions, including (1) making loans available on favorable terms that help with development of necessary health care

infrastructure, including community-based providers of medical home services and community-based preventive care service providers; (2) offering 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 SustiNet implementation; and (3) the offering of continuing medical education courses for physicians, nurses, and other clinicians, including training in culturally competent delivery of health care services.

Health Care Providers Who Can Serve as a Medical Home

Under the bill, the committee must make recommendations on entities that can be a medical home including 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 make recommendations on the medical home provider's responsibilities. These include that (1) each medical home provider be given a list of all medical home functions and (2) 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 other entities or individuals must be certified by the board based on the quality, safety, and efficiency of the service they provide. At the medical home provider's request, the board 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 make recommendations concerning payment for medical home functions including that (1) all of the bill's medical home functions are reimbursable under the SustiNet Plan; (2) in setting payment levels for those functions that are not normally reimbursed by commercial insurers, payment cover the full cost of services; and (3) rate-setting mechanisms can include using Medicare rate-setting methods or setting a monthly case management fee.

The committee must make recommendations that specialty referrals include prior consultation between the specialist and the medical home to determine whether the referral is medically necessary. If so, the consultation must identify any tests or procedures that must be done or arranged by the medical home, before the specialty visit, to promote economic efficiencies. The bill requires the SustiNet Plan to reimburse the medical home and specialist for time spent on consultations.

§ 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 SustiNet 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 make recommendations 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 make recommendations on 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. The committee's recommendations must include that any review conducted be subject to the law's protections concerning peer review (CGS § 19a-17b).

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

The committee must make recommendations concerning the authority providing 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 make recommendations on providing free samples of generic or other prescription drugs to participating providers. And the committee must

recommend policies and procedures 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 that uses evolving medical research 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. Beginning July 1, 2010, the committee must annually submit its recommendations to the board.

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 has not been provided before 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

Nonstate Public Employers; State Employees, Retirees and Dependents; Nonprofits; and Small Businesses

The board may develop recommendations that ensure that, beginning July 1, 2012, nonstate public employers are offered the

benefits of the SustiNet Plan. The bill defines "nonstate public employer" as a municipality or other political subdivision of the state, including a board of education, quasi-public agency, or public library. The board may develop recommendations that permit the comptroller to offer the SustiNet Plan benefits to state employees, retirees, and their dependents (no date is specified in the bill for doing this). No changes in health care benefits can be implemented concerning plans administered according to the state employee health plan unless they are negotiated and agreed to by the state and the coalition committee (SEBAC) through the collective bargaining process.

Also under the bill, the board must develop recommendations that ensure that beginning July 1, 2012, employees of nonprofit organizations and small businesses are offered SustiNet Plan membership.

HUSKY PLAN Part A and B Beneficiaries

The board must develop recommendations to ensure that the HUSKY Plan Part A and Part B, Medicaid, and state-administered general assistance (SAGA) programs participate in the SustiNet Plan. These recommendations must also ensure that HUSKY Plan Part A and B benefits are extended, to the extent permitted by federal law, to adults with income at or below 300% of FPL.

Those Not Offered Employee Sponsored Insurance (ESI)

The bill requires the board to make recommendations to ensure that state residents not offered employer sponsored insurance **(**ESI**)** and who do not qualify for HUSKY Part A and B, Medicaid, or SAGA can enroll in SustiNet beginning July 1, 2012. These recommendations must ensure that premium variation based on member characteristics does not exceed in total amount or in consideration of individual health risk, the variation permitted for a small employer carrier.

Those Offered Unaffordable or Inadequate ESI

The board must make recommendations to provide an option for enrollment in SustiNet to state residents who are offered ESI whose

household income is 400% of FPL or less. The board may make recommendations for establishing (1) a procedure for those individuals who demonstrate eligibility to enroll in SustiNet according to this provision and (2) a way to collect payments from employers whose employees would have received ESI, but instead enroll in SustiNet.

§ 10 — OFFERING SUSTINET TO EMPLOYERS THROUGH EXISTING CHANNELS

The bill requires the board to make recommendations concerning (1) use of various ways to sell SustiNet to employers, including public and private purchasing pools, agents, and brokers; (2) offering multi-year contracts to employers that have predictable premiums; (3) policies and procedures to ensure that employers can easily and conveniently purchase SustiNet plan coverage for their workers and dependents including participation requirements, timing of enrollment, open enrollment, enrollment length, and other matters deemed appropriate by the board; (4) 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); (5) availability of SustiNet Plan coverage for small employers on and after July 1, 2012 with premiums based on member characteristics as permitted for small employer carriers; (6) availability of SustiNet plan coverage for larger employers with premiums to prevent adverse selection, taking into account past claims experience, changes in characteristics of covered employees and dependents since the most recent time period covered by claims data, and other board-approved factors; and (7) the availability of a standard benefits package that cannot be any less comprehensive than the model benefits packages established by the bill (see § 12).

§ 11 — INFORMATION CLEARINGHOUSE

Under the bill, the board must recommend the establishment of 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 clearinghouse must develop data specifications that show comprehensive 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. OHA must develop the specifications in consultation 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 any information such a plan provides is limited, based on negotiations between the clearinghouse and the plan.

The clearinghouse must make its information public and update it annually. It must avoid disseminating information that identifies individual patients or providers. To the extent possible, it must also, adjust outcomes based on patient risk levels.

The clearinghouse must collect data based on each plan's provision of services over continuous 12-month periods. The clearinghouse must make public all information required by this section, subject to the limitations described above, no later than August 1, 2013, with updated information provided annually each August.

§ 12 — MODEL BENEFITS PACKAGES

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 evolving 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 on the updated model benefit

package.

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. Any modification of the standard benefit package by the board must ensure compliance with statutory coverage mandates and utilization review requirements.

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, 2012, OHA must report on these guidelines and recommendations to the governor, comptroller, and the Public Health, Labor and Public Employees, and Appropriations committees.

§ 13 — PUBLIC EDUCATION AND OUTREACH CAMPAIGNS

The bill requires the board to develop recommendations for 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.

§ 14 — IDENTIFICATION OF THE UNINSURED

The board, in collaboration with state and municipal agencies, must, within available appropriations, 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 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 identifying uninsured individuals who seek health care and transmitting such information to the board.

§ 15 — IDENTIFYING UNINSURED CHILDREN

The bill directs the Department of Social Services 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 these procedures to cover enrollment in the SustiNet Plan.

§ 16 — 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, except for the governor's appointee, 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, and the first meeting must be held within the same time frame. 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 passage. 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.

§ 17 — 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 reduce in tobacco use. 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; and

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, except for the governor's appointee.

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 pro tempore.

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.

§ 18 — 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. one academic expert on health care workforce, appointed by the Senate president pro tempore;

3. one academic expert in health care, appointed by the governor;

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

5. 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. Members, except for the governor's appointee, can be members of the General Assembly. 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 (File 920) 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)