



General Assembly

Substitute Bill No. 6600

January Session, 2009

* HB06600HS 042209 *

AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

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

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

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

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

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

17 (4) "Standard benefits package" means a set of covered benefits,

18 with out-of-pocket cost-sharing limits and provider network rules,
19 subject to the same coverage mandates that apply to small group
20 health insurance sold in this state. The standard benefits package
21 includes the following:

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

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

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

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

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

43 (F) Coverage of mental and behavioral health services, including
44 tobacco cessation services, substance abuse treatment services, and
45 services that prevent and treat obesity with such services being at
46 parity with the coverage for physical health services; and

47 (G) Dental care coverage that is comparable in scope to the median

48 coverage provided to employees by large employers in the Northeast
49 states; provided, in defining large employers, the authority may take
50 into account the capacity of available data to yield, without substantial
51 expense, reliable estimates of median dental coverage offered by such
52 employers;

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

56 (6) "Small employer" (A) means any person, firm, corporation,
57 limited liability company, partnership or association actively engaged
58 in business or self-employed for at least three consecutive months
59 who, on at least fifty per cent of its working days during the preceding
60 twelve months, employed no more than fifty eligible employees, the
61 majority of whom were employed within this state. "Small employer"
62 includes a self-employed individual, a municipality procuring health
63 insurance pursuant to section 5-259 of the general statutes, a private
64 school in this state procuring health insurance through a health
65 insurance plan or an insurance arrangement sponsored by an
66 association of such private schools, a nonprofit organization procuring
67 health insurance pursuant to said section 5-259, an association for
68 personal care assistants procuring health insurance pursuant to said
69 section 5-259, or a community action agency procuring health
70 insurance pursuant to said section 5-259. (B) In determining the
71 number of eligible employees for purposes of subparagraph (A) of this
72 subdivision, companies that are affiliated companies, as defined in
73 section 33-840 of the general statutes, or that are eligible to file a
74 combined tax return for purposes of taxation under chapter 208 of the
75 general statutes shall be considered one employer and eligible
76 employees shall not include employees covered through the employer
77 by health insurance plans or insurance arrangements issued to or in
78 accordance with a trust established pursuant to collective bargaining
79 subject to the federal Labor Management Relations Act. (C) Except as
80 otherwise specifically provided, provisions of sections 12-201, 12-211,
81 12-212a and 38a-564 to 38a-572, inclusive, of the general statutes that

82 apply to a small employer shall continue to apply until the plan
83 anniversary following the date the employer no longer meets the
84 requirements of subparagraph (A) of this subdivision;

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

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

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

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

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

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

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

105 Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is created a body
106 politic and corporate to be known as the "SustiNet Authority". Said
107 authority is constituted a public instrumentality and political
108 subdivision of the state and the exercise by the authority of the powers
109 conferred by this section shall be deemed and held to be the
110 performance of an essential public and governmental function. The
111 board of directors of said authority shall consist of nine members,

112 seven of whom shall be appointed as follows: One appointed by the
113 Governor, who shall be an expert on health economics; one appointed
114 by the president pro tempore of the Senate, who shall be an expert on
115 health care delivery, including primary care delivery; one appointed
116 by the speaker of the House of Representatives, who shall be a
117 representative of Medicaid and HUSKY Plan beneficiaries; one
118 appointed by the majority leader of the Senate, who shall be a
119 representative of the Connecticut Hospital Association; one appointed
120 by the majority leader of the House of Representatives, who shall be a
121 representative of the Connecticut State Medical Society; one appointed
122 by the minority leader of the Senate, who shall be a representative of
123 the Connecticut Nurses' Association; and one appointed by the
124 minority leader of the House of Representatives, who shall be a
125 representative of private employers; two appointed by the coalition
126 committee established pursuant to subsection (f) of section 5-278 of the
127 general statutes, one of whom shall be a representative of labor unions
128 and one of whom shall be a representative of business management.
129 The Commissioners of Social Services, Public Health, and Mental
130 Health and Addiction Services, the Insurance Commissioner and the
131 Comptroller shall be ex-officio, nonvoting members of the board of
132 directors.

133 (b) Initial appointments to the board of directors shall be made on or
134 before August 15, 2009. (1) Board members appointed by the coalition
135 committee shall serve at the pleasure of said committee. (2) The initial
136 term for the board member appointed by the Governor and the
137 president pro tempore of the Senate shall be for two years. The initial
138 term for board members appointed by the speaker of the House of
139 Representatives and the majority leader of the Senate shall be for three
140 years. The initial term for board members appointed by the majority
141 leader of the House of Representatives and the minority leader of the
142 Senate shall be for four years. The initial term for the board member
143 appointed by the minority leader of the House of Representatives shall
144 be for five years. Terms pursuant to this subdivision shall expire on
145 June thirtieth in accordance with the provisions of this subdivision.

146 Not later than thirty days prior to the expiration of a term as provided
147 for in this subsection, the appointing authority may reappoint the
148 current board member or shall appoint a new member to the board.
149 Other than an initial term, a board member shall serve for a term of
150 five years and until a successor board member is appointed. A member
151 of the board pursuant to this subdivision shall be eligible for
152 reappointment. (3) Any member of the board may be removed by the
153 appropriate appointing authority for misfeasance, malfeasance or
154 wilful neglect of duty. Each member of the board shall take and
155 subscribe the oath or affirmation required by article XI, section 1, of the
156 State Constitution prior to assuming such office. A record of each such
157 oath shall be filed in the office of the Secretary of the State.

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

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

177 (e) The powers of the authority shall be vested in and exercised by
178 the board of directors. Six of the voting members of the board shall

179 constitute a quorum at any meeting of the board. No vacancy in the
180 membership of the board shall impair the right of such members to
181 exercise all the rights and perform all the duties of the board. Any
182 action taken by the board under the provisions of sections 1 to 18,
183 inclusive, 20 to 22, inclusive, and 24 to 26, inclusive, of this act may be
184 authorized by resolution approved by a majority of the members
185 present at any regular or special meeting, which resolution shall take
186 effect immediately or by a resolution circulated or sent to each member
187 of the board, which shall take effect at such time as a majority of the
188 members shall have signed an assent to such resolution. Resolutions of
189 the board shall be made publicly available through the Internet and
190 through such other modalities as the board deems appropriate. Board
191 meetings shall be open to the public, provided the board may meet in
192 executive session, in accordance with chapter 14 of the general statutes,
193 to discuss personnel and other proprietary matters. Notice of a board
194 meeting and any agenda for such meeting shall be publicly available
195 through the Internet and through such other modalities as the board
196 deems appropriate. Board meetings shall be held from time to time in
197 diverse localities throughout the state. The board shall invite public
198 comment at all meetings and such comment shall be included in the
199 record for such meeting. Public comment will be included in meeting
200 records. The board may delegate by resolution to three or more of its
201 members such powers and duties as it may deem proper. At least one
202 of such members shall not be a state employee.

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

213 Secretary of the State. The cost of each such bond shall be paid by the
214 authority.

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

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

229 (i) The board of directors of the authority shall adopt written
230 procedures, in accordance with the provisions of section 1-121 of the
231 general statutes, for: (1) Adopting an annual budget and plan of
232 operations, including a requirement of board approval before the
233 budget or plan may take effect; (2) hiring, dismissing, promoting and
234 compensating employees of the authority, including an affirmative
235 action policy and a policy determining the extent to which board
236 approval is required before a position may be created or a vacancy
237 filled; (3) acquiring real and personal property and personal services,
238 including a requirement of board approval for any nonbudgeted
239 expenditure in excess of five thousand dollars; (4) contracting for
240 financial, legal, insurance, underwriting and other professional
241 services, including a requirement that the authority solicit proposals at
242 least once every three years for each such service that it uses; (5)
243 awarding loans, grants and other financial assistance, including
244 eligibility criteria, the application process and the role played by the
245 authority's staff and board of directors; and (6) contracting with

246 insurers or other entities for administrative purposes, such as claims
247 processing and credentialing of providers.

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

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

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

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

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

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

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

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

271 (5) To adopt guidelines, policies and regulations in accordance with
272 chapter 54 of the general statutes that are necessary to implement the
273 provisions of this section and sections 1 to 18, inclusive, 20 to 22,
274 inclusive, 24 to 26, inclusive, of this act;

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

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

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

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

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

306 (11) To commission surveys of consumers, employers and providers

307 on issues related to health care and health care coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

375 (c) The board shall adopt periodic action plans to achieve
376 measurable objectives in areas that include, but are not limited to,
377 effective management of chronic illness, preventive care, reducing
378 racial and ethnic disparities as related to health care and health
379 outcomes, and reducing the number of state residents without
380 insurance. The board shall monitor the accomplishment of such
381 objectives and modify action plans as necessary. The board's action
382 plans and progress made with respect to achieving the objectives of
383 such plans shall be included in the report prepared pursuant to section
384 22 of this act.

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

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

400 and (2) develop and implement procedures to ensure that physicians,
401 nurses, hospitals and other health care providers gain access to
402 hardware and approved software for interoperable electronic medical
403 records and the establishment of electronic health records for SustiNet
404 Plan members.

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

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

434 other services; (7) in the case of prescriptions, notice of potential
435 interactions with other drugs and past patient adverse reactions to
436 similar medications; (8) notice of possible violation of patient wishes
437 for end-of-life care; (9) notice of services provided inconsistently with
438 care guidelines adopted pursuant to section 8 of this act, along with
439 options that permit the convenient recording of reasons why such
440 guidelines are not being followed; and (10) such additional functions
441 as may be approved by the information technology committee.

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

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

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

465 (h) The board shall, within available appropriations, hire or contract

466 with health information technology professionals located in or serving
467 residents of this state whose responsibility shall be to assist subscribing
468 health care providers make effective and efficient use of the health
469 information technology provided pursuant to this section. Such
470 professional assistance shall include help selecting approved software
471 and hardware, training in and technical assistance with installation
472 and operation, and providing pertinent information for revising and
473 updating the applicable software and hardware.

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

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

496 (k) The board shall develop methods to eliminate or minimize
497 transition costs for health care providers that, prior to July 1, 2009,
498 implemented comprehensive systems of electronic medical records or

499 electronic health records. Such methods may include technical
500 assistance in transitioning to new software and development of
501 modules to help existing software connect to the integration system
502 described in subsection (i) of this section.

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

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

525 (n) The authority shall ensure that each participating provider uses
526 either approved software or other electronic medical record software
527 that is interoperable with approved software and the electronic health
528 record integration system described in subsection (i) of this section.
529 The board shall develop and implement appropriate financial
530 incentives for early subscriptions by participating providers, including
531 discounted fees for providers who do not delay their subscriptions. No

532 later than July 1, 2015, the board shall require as a condition of
533 participation in the SustiNet Plan that each participating provider uses
534 either approved software or other electronic medical record software
535 that is interoperable with approved software and the electronic health
536 record integration system described in subsection (i) of this section.
537 After July 1, 2015, the board may provide additional support to a
538 provider that demonstrates to the satisfaction of the board that such
539 provider would experience special hardship due to the
540 implementation of electronic medical records and electronic health
541 records requirements within the specified time frame. Such provider
542 may qualify for additional support and an exemption from compliance
543 with the time frame specified in this subsection, but only if such an
544 exemption is necessary to ensure that members in the geographic
545 locality served by the provider continue to receive excellent access to
546 care.

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

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

558 Sec. 6. (NEW) (*Effective July 1, 2009*) (a) The board shall establish a
559 medical home advisory committee that shall develop recommended
560 internal procedures and proposed regulations governing the
561 administration of patient-centered medical homes that provide health
562 care services to SustiNet Plan members. The medical home advisory
563 committee shall forward their recommended internal procedures and
564 proposed regulations to the board in accordance with such time and

565 format requirements as may be prescribed by the board. The medical
566 home advisory committee shall be composed of physicians, nurses,
567 consumer representatives and other qualified individuals chosen by
568 the board.

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

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

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

589 (2) Care coordination that includes: (A) Managing transitions
590 between home and the hospital; (B) proactive monitoring to ensure
591 that the member receives all recommended primary and preventive
592 care services; (C) the provision of basic mental health care, including
593 screening for depression, with referral relationships in place for those
594 members who require additional assistance; (D) strategies to address
595 stresses that arise in the workplace, home, school and the community,
596 including coordination with and referrals to available employee

597 assistance programs; (E) referrals, in appropriate cases, to nonmedical
598 services such as housing and nutrition programs, domestic violence
599 resources and other support groups; and (F) for a member with a
600 complex health condition that involves care from multiple providers,
601 ensuring that such providers share information about the member, as
602 appropriate, and pursue a single, integrated treatment plan; and

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

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

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

630 arrangements required for a qualified entity or individual to perform
631 any medical home function not assumed by the core provider.

632 (f) The board, in consultation with the medical home advisory
633 committee, shall develop, monitor and enforce quality and safety
634 standards for medical home functions that are not covered by existing
635 professional standards, which may include care coordination and
636 member education.

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

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

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

662 Sec. 7. (NEW) (*Effective July 1, 2009*) (a) The board shall establish a
663 health care provider committee that shall develop recommended
664 clinical care and safety guidelines for use by participating health care
665 providers. The committee shall choose from nationally and
666 internationally recognized guidelines for the provision of care,
667 including guidelines for hospital safety and the inpatient and
668 outpatient treatment of particular conditions. The committee shall
669 continually assess the quality of evidence relevant to the costs, risks
670 and benefits of treatments described in such guidelines. The health
671 care provider committee shall forward their recommended clinical care
672 and safety guidelines to the board in accordance with such time and
673 format requirements as may be prescribed by the board. The health
674 care provider committee shall include both health care consumers and
675 health care providers.

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

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

695 (d) The board shall develop procedures that require hospitals and
696 their medical staffs, physicians, nurse practitioners, and other
697 participating health care providers to engage in periodic reviews of
698 their quality of care. The purpose of such reviews shall be to develop
699 plans for quality improvement. Such reviews shall include the
700 identification of potential problems manifesting as adverse events or
701 events that could have resulted in negative patient outcomes. As
702 appropriate, such reviews shall incorporate confidential consultation
703 with peers and colleagues, opportunities for continuing medical
704 education, and other interventions and supports to improve
705 performance. To the maximum extent permissible, such reviews shall
706 incorporate existing peer review mechanisms. Any review conducted
707 in accordance with the provisions of this subsection shall be subject to
708 the protections afforded by section 19a-17b of the general statutes.

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

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

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

726 Sec. 8. (NEW) (*Effective July 1, 2009*) (a) The board shall establish a

727 preventive health care committee that shall use evolving medical
728 research to draft recommendations to improve health outcomes for
729 members in areas involving nutrition, sleep, physical exercise, and the
730 prevention and cessation of the use of tobacco and other addictive
731 substances. The committee shall include providers, consumers and
732 other individuals chosen by the board. Such recommendations may be
733 targeted to member populations where they are most likely to have a
734 beneficial impact on the health of such members and may include
735 behavioral components and financial incentives for participants. Such
736 recommendations shall take into account existing preventive care
737 programs administered by the state, including, but not limited to, state
738 administered educational and awareness campaigns. Not later than
739 July 1, 2010, and annually thereafter, the preventative health
740 committee shall submit such recommendations, in accordance with
741 section 11-4a of the general statutes, to the board and to the joint
742 standing committees of the General Assembly having cognizance of
743 matters relating to public health, appropriations and the budgets of
744 state agencies and finance, revenue and bonding. Any
745 recommendation of the committee that does not require legislative
746 action may be presented to the board at any time.

747 (b) The Sustinet Plan shall provide coverage for community-based
748 preventive care services and such services shall be required of all
749 health insurance sold pursuant to the plan to individuals or employers.
750 Community-based preventive care services are those services
751 identified by the board as capable of being safely administered in
752 community settings. Such services shall include, but not be limited to,
753 immunizations, simple tests and health care screenings. Such services
754 shall be provided by individuals or entities who satisfy board-
755 approved standards for quality of care. Prior to furnishing a
756 community-based preventive care service, a provider shall obtain
757 information from a patient's electronic health record to verify that the
758 service has not been provided in the past and that such services are not
759 contraindicated for the patient. A provider shall promptly furnish
760 relevant information about the service and the results of any test or

761 screening to the patient's medical home or the patient's primary care
762 provider if the patient does not have a medical home. Community-
763 based preventive services may be provided at job sites, schools or
764 other community locations consistent with the board's guidelines.

765 Sec. 9. (NEW) (*Effective July 1, 2009*) (a) The board shall develop
766 policies and procedures that ensure that, on and after July 1, 2011,
767 Sustinet Plan membership is offered, as the form of employer-
768 sponsored insurance furnished by the state, to all state employees and
769 retirees and their dependents who qualify for health insurance
770 coverage under state law, including those who would have qualified
771 under state law as of January 1, 2009. The benefits, access to providers
772 and out-of-pocket cost-sharing rules that apply to such members shall
773 be consistent with all collective bargaining agreements that apply to
774 such members. Only a Sustinet Plan member described in this
775 subsection shall have his or her claims or other health care costs paid,
776 in whole or in part, by payments for coverage of state employees and
777 retirees described in this subsection. The coalition committee
778 established pursuant to subsection (f) of section 5-278 of the general
779 statutes shall retain jurisdiction over policy and practice matters that
780 pertain exclusively to coverage for state employees and retirees. The
781 coalition committee may overrule any decision of the board to the
782 extent that such decision (1) would apply to state employees, retirees
783 or their dependents; and (2) when compared to governing laws in
784 effect on January 1, 2009, would reduce benefits, increase costs to
785 enrollees, reduce access to care or lower the quality of care provided to
786 individuals described in this subsection. The board shall take no action
787 that impinges on a collective bargaining agreement applicable to state
788 employees and retirees and such collective bargaining agreement shall
789 remain in full force and effect unless amended.

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

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

798 (2) For HUSKY Plan providers enrolled in the Sustinet Plan,
799 provider reimbursement levels gradually increase above levels in
800 effect on June 30, 2009, so that on and after July 1, 2011, per member
801 per month costs, calculated separately for children and for adults, do
802 not fall below the percentages of median costs for large group
803 coverage in this state.

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

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

811 (A) Medicare;

812 (B) Supplemental Security Income; or

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

819 (c) The board shall develop policies and procedures to ensure that
820 on and after July 1, 2011, state residents who are not offered employer-
821 sponsored insurance and who do not qualify for Medicare are
822 permitted to enroll in the Sustinet Plan. Individuals with incomes
823 above three hundred per cent of the federal poverty level shall receive

824 a standard benefits package, unless such individuals choose to buy
825 more comprehensive coverage, in which case such individuals,
826 irrespective of income levels, shall pay the full increase in the premium
827 amount needed to cover their proportionate share of the claims
828 incurred by all individuals who purchase such comprehensive
829 coverage. Individuals with income:

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

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

858 per cent of the federal poverty level.

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

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

887 (e) For purposes of this subsection, "employer voucher" means the
888 amount an employer would have paid for an individual employee's
889 premiums if the individual employee had accepted the offer of
890 employer-sponsored insurance. If an individual enrolls in the Sustinet

891 Plan pursuant to subsection (d) of this section, the individual's
892 employer shall pay to the authority an employer voucher, which shall
893 be deposited in the Sustinet account established in section 15 of this
894 act. An employer's payment of employer vouchers shall be limited as
895 follows:

896 (1) The number of employer vouchers for a particular employer,
897 when added to the number of individuals who accept the employer's
898 offer of coverage, shall not exceed the average percentage of
899 employees and dependents, calculated separately, who accept
900 employer-sponsored insurance offers in Northeast states for firms of
901 the same general size and industry, as determined by the board; and

902 (2) The cost of employer vouchers, plus the amount the employer
903 pays for employer-sponsored insurance premiums, shall not exceed
904 what the employer would have paid for employer-sponsored health
905 care coverage but for the implementation of sections 1 to 18, inclusive,
906 20 to 22, inclusive, and 24 to 26, inclusive. The board shall establish an
907 administrative procedure to allow an employer to establish that the
908 cost of employer vouchers, when added to the cost that the employer
909 pays for employer-sponsored insurance premiums, exceeds the cost
910 that the employer would have paid had the provisions of this section
911 not been implemented. If the employer prevails in such administrative
912 proceeding, the authority shall pay the employer's reasonable costs
913 and attorneys' fees.

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

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

923 (2) The amount of any unpaid premiums during a calendar year
924 shall be added to the individual's state income tax liability for the
925 calendar year, with interest and penalties determined by treating the
926 unpaid premium payments as state income tax obligations. Prior to the
927 board informing the Department of Revenue Services that an
928 individual enrollee did not pay required premiums to the SustiNet
929 Plan, the board shall provide notice and an opportunity to be heard to
930 the individual enrollee so as to allow such individual enrollee the
931 ability to challenge the board's determination that he or she did not
932 pay required premiums to the SustiNet Plan or to allow such
933 individual enrollee to arrange payment terms satisfactory to the board
934 that do not involve a referral of the individual enrollee to the
935 Department of Revenue Services. The board and the Department of
936 Revenue Services shall develop procedures through which the
937 additional income tax payment made under this subsection is
938 forwarded to the SustiNet account established in accordance with the
939 provisions of section 15 of this act.

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

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

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

961 (d) Beginning on July 1, 2015, employers that are not small
962 employers may purchase SustiNet Plan coverage. The authority may
963 vary the premiums charged to such employers to prevent adverse
964 selection, taking into account past claims experience, changes in the
965 characteristics of covered employees and dependents since the most
966 recent time period covered by claims data, and other factors approved
967 by the board.

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

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

982 Sec. 11. (NEW) (*Effective July 1, 2009*) (a) As used in sections 11 and
983 12 of this act, "clearinghouse" means an independent information
984 clearinghouse that is: (1) Established and overseen by the Office of the
985 Healthcare Advocate; (2) operated by an independent research
986 organization that contracts with the Office of the Healthcare Advocate;
987 and (3) responsible for providing employers, individual purchasers of
988 health coverage, and the general public with comprehensive

989 information about the care covered by the SustiNet Plan and by
990 private health plans.

991 (b) The clearinghouse shall develop specifications for data that show
992 for each health plan, quality of care, outcomes for particular health
993 conditions, access to care, utilization of services, adequacy of provider
994 networks, patient satisfaction, rates of disenrollment, grievances and
995 complaints, and any other factors the Office of the Healthcare
996 Advocate determines relevant to assessing health plan performance
997 and value. In developing such specifications, the Office of the
998 Healthcare Advocate shall consult with private insurers and with the
999 board.

1000 (c) The following entities shall provide data to the clearinghouse in
1001 a time and manner as prescribed by the Office of the Healthcare
1002 Advocate: (1) The SustiNet Plan; (2) health insurers, as a condition of
1003 licensure; and (3) any self-insured group plan that volunteers to
1004 provide data. Dissemination of any information provided by a self-
1005 insured group plan shall be limited and in conformity with a written
1006 agreement governing such dissemination as developed and approved
1007 by the group plan and the Office of the Healthcare Advocate.

1008 (d) Except as provided for in subsection (c) of this section, the
1009 clearinghouse shall make public all information provided pursuant to
1010 subsection (b) of this section. The clearinghouse shall not disseminate
1011 any information that identifies individual patients or providers. The
1012 clearinghouse shall adjust outcomes based on patient risk levels, to the
1013 maximum extent possible. The clearinghouse shall make information
1014 available in multiple forms and languages, taking into account varying
1015 needs for the information and different methods of processing such
1016 information.

1017 (e) The clearinghouse shall collect data based on each plan's
1018 provision of services over continuous twelve-month periods. Except as
1019 provided in subsection (c) of this section, the clearinghouse shall make
1020 public all information required by this section no later than August 1,

1021 2012, with updated information provided each August first thereafter.

1022 Sec. 12. (NEW) (*Effective July 1, 2009*) The intentional interference
1023 with fair and open competition between health insurers, which
1024 includes failure to report information accurately and completely to the
1025 clearinghouse as required by section 11 of this act, discouraging the
1026 offering of high-value private coverage in order to provide a
1027 competitive advantage to the Sustinet Plan, otherwise reducing the
1028 effectiveness or efficiency of one health plan in order to provide a
1029 competitive advantage to another health plan, and intentional
1030 misrepresentations about covered benefits, costs, provider networks or
1031 plan performance, shall be subject to the provisions of section 1-89 of
1032 the general statutes. Fines, penalties and damages prescribed pursuant
1033 to said section shall be in addition to any other remedies that are
1034 available under state or federal law. For purposes of this section, the
1035 term "health insurer" shall include the Sustinet Plan, employer-
1036 sponsored health coverage and any individual or group insurance sold
1037 in the state.

1038 Sec. 13. (NEW) (*Effective July 1, 2009*) (a) To the extent permitted by
1039 federal law, the Commissioner of Social Services shall take all steps
1040 necessary to ensure that on and after July 1, 2011, eligibility for
1041 enrollment in the HUSKY Plan, Part A includes all adults with incomes
1042 at or below one hundred eighty-five per cent of the federal poverty
1043 level, whether or not such adults are the custodial parents or caretaker
1044 relatives of minor children.

1045 (b) The Commissioner of Social Services shall, to the extent
1046 permitted by federal law, take all steps necessary to ensure that on and
1047 after July 1, 2011, eligibility for enrollment in the HUSKY Plan, Part B
1048 includes adults with incomes from one hundred eighty-six per cent of
1049 the federal poverty level to three hundred per cent of the federal
1050 poverty level, inclusive. Such adults shall receive services and be
1051 responsible for cost-sharing requirements comparable to those
1052 imposed on households with children receiving HUSKY Plan, Part B
1053 benefits at the same income level, calculated as a percentage of the

1054 federal poverty level, taking into account the differential utilization of
1055 and need for services between adults and children. Adult enrollees in
1056 the HUSKY Plan, Part B program shall be charged a premium payment
1057 that is not less than twice the amount charged to the household of a
1058 child enrollee at the same income level, calculated as a percentage of
1059 the federal poverty level.

1060 (c) On and after July 1, 2011, to the extent permitted by federal law,
1061 immigration status shall not be a factor in determining eligibility for
1062 the HUSKY Plan, Part A or Part B, or for Sustinet premium subsidies.
1063 The Sustinet Authority and the Department of Social Services shall
1064 take all reasonable measures to maximize receipt of federal matching
1065 funds for the purposes of this subsection, provided state funds shall be
1066 used to the extent necessary to provide eligible individuals with health
1067 care insurance coverage in accordance with the provisions of this
1068 subsection.

1069 Sec. 14. (NEW) (*Effective July 1, 2009*) Notwithstanding any
1070 provision of the general statutes, on and after July 1, 2011, individual
1071 health insurance policies may not be sold in the state unless they meet
1072 the following requirements: (1) Premiums for such policies may not
1073 vary based on individual characteristics except for the reasons and to
1074 the extent that such premiums are permitted to vary for the small
1075 group market; and (2) preexisting conditions may not be excluded
1076 when issuing such policies, except in circumstances when such
1077 exclusion would be permitted if the health insurance policy were for
1078 the small group market.

1079 Sec. 15. (NEW) (*Effective July 1, 2009*) (a) There is established an
1080 account to be known as the "Sustinet account" which shall be a
1081 separate, nonlapsing account within the General Fund. The account
1082 shall contain any moneys required by law to be deposited in the
1083 account. Investment earnings credited to the assets of the account shall
1084 become part of the assets of the account. The moneys in the account
1085 shall be used to defray the costs to the state of providing health care
1086 coverage under the Sustinet Plan, including related administrative

1087 costs. The Sustinet Authority shall be responsible for the disbursement
1088 of moneys from this account.

1089 (b) The Sustinet Authority shall assist the Department of Social
1090 Services with the department's efforts to maximize the amount of
1091 federal matching funds used to help finance Medicaid, HUSKY Plan,
1092 Part A and Part B and Sustinet premium subsidies. The department's
1093 efforts shall include seeking any waivers under Titles XIX and XXI of
1094 the Social Security Act that are required for the effective
1095 implementation of the Sustinet Plan, including a waiver, under
1096 Section 1115 of said act, to obtain the maximum amount of federal
1097 matching funds to provide coverage for adults under the programs
1098 described in this subsection.

1099 (c) The authority and the Department of Social Services shall ensure,
1100 to the maximum extent permitted by federal law, that the cost of
1101 providing Sustinet services to individuals eligible for the HUSKY
1102 Plan, Parts A and B, and Sustinet premium subsidies, along with
1103 related administrative costs, are funded by deposits into the account
1104 established pursuant to subsection (a) of this section. Such deposits
1105 shall include any federal funds available to the state under Title XXI of
1106 the Social Security Act, as amended from time to time, that the state
1107 would otherwise not obtain, any federal matching funds provided
1108 under Titles XIX and XXI of said act that are available for services
1109 provided to Sustinet Plan members and any appropriations approved
1110 by the General Assembly for maintenance of effort payments as
1111 described in subsection (f) of this section.

1112 (d) The authority shall determine the appropriate insurance
1113 premium contributions from individual enrollees and shall ensure that
1114 such contributions are deposited into the account established pursuant
1115 to subsection (a) of this section.

1116 (e) (1) On and after January 1, 2012, any employer who does not
1117 offer group health insurance coverage to its employees and has a total
1118 payroll above the threshold amounts determined by the Department of

1119 Revenue Services pursuant to subdivision (2) of this subsection, shall
1120 be required to make annual shared responsibility payments as set forth
1121 in this subsection. The employees of such employer shall also be
1122 required to make annual shared responsibility payments as set forth in
1123 subdivision (3) of this subsection. Employer and employee shared
1124 responsibility payments shall be deposited in the account established
1125 pursuant to subsection (a) of this section. The Department of Revenue
1126 Services, in consultation with the board, shall develop polices and
1127 procedures to effectuate the collection of shared responsibility
1128 payments that minimize the administrative burden on employers by
1129 collecting such payments through a modification to the existing
1130 payroll tax collection system.

1131 (2) The Department of Revenue Services shall establish the
1132 threshold amounts that shall be based on the estimated average annual
1133 payroll for a private sector employer having ten employees. The
1134 Department of Revenue Services shall publish the threshold amount
1135 for a calendar year no later than October first of the preceding calendar
1136 year so that shared responsibility payments can be properly calculated
1137 and withheld by an employer.

1138 (3) If an employer has total payroll above the threshold amount
1139 established pursuant to subdivision (2) of this subsection and such
1140 employer fails to offer health insurance coverage to its employees,
1141 such employer shall be responsible for making annual shared
1142 responsibility payments equal to the three per cent of such employer's
1143 payroll that is above the established threshold amount. The employees
1144 of such employer described shall collectively pay an amount equal to
1145 one per cent of the employer's payroll that is above the established
1146 threshold amount. The board, in consultation with the Department of
1147 Revenue Services, shall develop methods of collecting shared
1148 responsibility payments and allotting the employees' share equitably,
1149 based on earnings statements received from the applicable employer.
1150 For limited liability companies, S corporations and similar business
1151 entities, calculation of payroll amounts required to accomplish the
1152 purposes of this subsection shall equal the income that is subject to

1153 federal payroll taxation or federal self-employment taxation.

1154 (f) For purposes of this subsection, "maintenance of effort payments"
1155 means total state health care expenditures that would have been
1156 incurred had the Sustinet Plan not been implemented. On or before
1157 December 31, 2009, and annually thereafter, the board shall report, in
1158 accordance with section 11-4a of the general statutes, to the Governor,
1159 the State Comptroller and the joint standing committees of the General
1160 Assembly having cognizance of matters relating to public health,
1161 human services, labor and public employees, and appropriations and
1162 the budgets of state agencies on certified estimates of the maintenance
1163 of effort payments that are needed for the succeeding two fiscal years.
1164 Maintenance of effort payment estimates reported pursuant to this
1165 subsection shall take into account changes in average per capita health
1166 spending on a national level and the effects of state macroeconomic
1167 conditions on state-sponsored health care had the Sustinet Plan not
1168 been implemented. The board, in its discretion, may submit revised
1169 estimates, in accordance with the provisions of this subsection, if such
1170 revised estimates would have a significant impact on the
1171 administration of the Sustinet Plan.

1172 Sec. 16. (NEW) (*Effective July 1, 2009*) (a) The Office of Healthcare
1173 Advocate shall develop and update the model benefit packages, based
1174 on evolving medical evidence and scientific literature, that make the
1175 greatest possible contribution to enrollee health for a premium cost
1176 typical of private, employer-sponsored insurance in the Northeast
1177 states. Not later than December 1, 2010, and biennially thereafter, the
1178 Office of Healthcare Advocate shall report, in accordance with the
1179 provisions of section 11-4a of the general statutes, to the board and to
1180 the joint standing committees of the General Assembly having
1181 cognizance of matters relating to public health, human services, labor
1182 and public employees, appropriations and the budgets of state
1183 agencies and finance, revenue and bonding on the updated model
1184 benefit packages. The Office of Healthcare Advocate may contract with
1185 an independent, expert research organization for assistance in
1186 producing the report required by this subsection.

1187 (b) After the promulgation of the model benefit packages, as
1188 provided in subsection (a) of this section, the board may modify the
1189 standard benefits package if the board determines that: (1) Such
1190 modification would yield better outcomes for an equivalent
1191 expenditure of funds; or (2) providing additional coverage or reduced
1192 cost-sharing for particular services as provided to particular enrollee
1193 populations may reduce net costs or provide sufficient improvements
1194 to health outcomes to warrant the resulting increase in net costs.

1195 (c) The Office of the Healthcare Advocate shall recommend
1196 guidelines for establishing an incentive system that recognizes
1197 employers who provide employees with health insurance benefits that
1198 are equal to or more comprehensive than the model benefit packages.
1199 Such incentives may include public recognition of employers who
1200 offer such comprehensive benefits. Not later than December 1, 2010,
1201 the Office of the Healthcare Advocate shall report, in accordance with
1202 section 11-4a of the general statutes, on such guidelines and
1203 recommendations to the Governor, the State Comptroller and the joint
1204 standing committees of the General Assembly having cognizance of
1205 matters relating to public health, labor and public employees, and
1206 appropriations and the budgets of state agencies.

1207 Sec. 17. (NEW) (*Effective July 1, 2009*) (a) The authority shall develop
1208 and implement public education and outreach campaigns to ensure
1209 that state residents are informed about the Sustinet Plan and are
1210 encouraged to enroll in the plan.

1211 (b) This public education and outreach campaign shall utilize
1212 community-based organizations and shall include a focus on targeting
1213 populations that are underserved by the health care delivery system.

1214 (c) The public education and outreach campaign shall be based on
1215 evidence of the cost and effectiveness of similar efforts in this state and
1216 elsewhere. Such campaign shall incorporate an ongoing evaluation of
1217 its effectiveness, with corresponding changes in strategy, as needed.

1218 Sec. 18. (NEW) (*Effective July 1, 2009*) (a) The board, in collaboration

1219 with state and municipal agencies, shall, within available
1220 appropriations, develop and implement systematic methods to
1221 identify uninsured individuals in the state. Such methods shall
1222 include:

1223 (1) Not later than July 1, 2011, the Department of Revenue Services
1224 shall, within available appropriations, modify state income tax forms
1225 to request that a taxpayer identify existing health coverage for each
1226 member of the taxpayer's household. The Department of Revenue
1227 Services shall, within available appropriations, inform taxpayers that
1228 they may elect to restrict disclosure of income information contained in
1229 tax returns data, but that such election may impede the taxpayer's
1230 ability to obtain free or low-cost health insurance coverage. If a
1231 taxpayer indicates on a tax return that any member of the household is
1232 without health insurance coverage, such information shall be disclosed
1233 by the Department of Revenue Services to the board and the
1234 Department of Social Services to determine whether such taxpayer
1235 qualifies for free or low-cost health insurance coverage and to enroll
1236 such taxpayer into coverage. The Department of Revenue Services, the
1237 board and the Department of Social Services shall, within available
1238 appropriations, develop methods for the efficient, electronic
1239 transmission of information described in this subdivision to the board
1240 and the Department of Social Services for purposes of identifying
1241 uninsured individuals and determining eligibility for HUSKY Plan,
1242 Part A or Part B coverage, SustiNet premium subsidies and other
1243 sources of coverage, and enrolling such individuals promptly into
1244 health insurance coverage.

1245 (2) Not later than July 1, 2011, the Labor Department shall, within
1246 available appropriations, modify application forms for initial and
1247 continuing claims for unemployment insurance to request information
1248 about health insurance status for the applicant and the applicant's
1249 dependents. Such modifications shall clearly advise the applicant that
1250 information concerning an individual identified as being without
1251 health insurance coverage shall be transmitted to the board and to the
1252 Department of Social Services for a determination of eligibility for free

1253 or low-cost health insurance coverage and for potential enrollment into
1254 such health insurance coverage. The Labor Department, the board and
1255 the Department of Social Services shall, within available
1256 appropriations, develop methods for the efficient, electronic
1257 transmission of information described in this subdivision to the board
1258 and the Department of Social Services for purposes of identifying
1259 uninsured individuals, determining their eligibility for HUSKY Plan,
1260 Part A or Part B coverage, SustiNet premium subsidies and other
1261 sources of coverage, and enrolling such individuals promptly into
1262 health insurance coverage.

1263 (3) Not later than July 1, 2011, the board, in collaboration with the
1264 Department of Social Services, shall develop a method by which
1265 hospitals, community health centers and other providers as
1266 determined by the board shall: (A) Identify uninsured individuals who
1267 seek health care, and (B) convey such information, via secure electronic
1268 mail transmission, to the board and said department to facilitate the
1269 potential enrollment of such individuals into health insurance
1270 coverage. The board shall develop procedures to ensure that, in such
1271 cases, the cost of care may be covered retroactively if an individual is
1272 enrolled in the SustiNet Plan.

1273 (b) The board, in collaboration with the Department of Social
1274 Services, shall, within available appropriations, identify individuals
1275 who may be uninsured by matching databases that identify
1276 individuals with health insurance coverage, including data about
1277 private health insurance coverage made available pursuant to Section
1278 6035 of the Deficit Reduction Act of 2005, against databases identifying
1279 state residents.

1280 (c) On and after July 1, 2011, prior to enrolling any individual who
1281 appears to lack health insurance coverage in a state-administered
1282 health insurance plan, the identity of such individual shall be cross-
1283 matched against Department of Social Services databases to ensure
1284 that such individual lacks health insurance coverage. The board shall
1285 develop notice and hearing procedures, consistent with those used for

1286 beneficiaries under Title XIX of the Social Security Act, that allow an
1287 individual to contest a determination concerning the individual's
1288 health insurance coverage.

1289 (d) On and after July 1, 2011, if an individual is determined to be
1290 uninsured, such individual may be enrolled in health insurance
1291 coverage in accordance with this subsection. Such individual shall
1292 receive notice that he or she is to be enrolled in health insurance
1293 coverage, with premiums charged based on income, not later than
1294 forty-five days after the date of receipt of such notice from the
1295 authority, unless such individual provides proof of coverage, contests
1296 the determination that he or she lacks health insurance coverage as
1297 provided for in subsection (c) of this section, or affirmatively opts to
1298 remain uninsured. An individual enrolled in health insurance
1299 coverage under the provisions of this subsection shall receive premium
1300 discounts if such individual agrees to expedite his or her premium
1301 payments through voluntary wage withholding or other method of
1302 electronic funds transfer.

1303 (1) Not later than July 1, 2011, an individual's initial income
1304 determination, for purposes of determining eligibility for HUSKY Plan,
1305 Part A and Part B and Sustinet premiums, shall be based on matches
1306 with all accessible, cost-effective sources of information concerning the
1307 individual's income, including, state income tax data, data available
1308 through the Enterprise Income Verification System, the National
1309 Directory of New Hires maintained by the Office of Child Support
1310 Enforcement within the United States Department of Health and
1311 Human Services, and information available from private vendors.

1312 (2) The board shall develop notice and hearing procedures,
1313 consistent with the procedures used under Title XIX of the Social
1314 Security Act, that allow an individual to challenge an initial income
1315 determination and demonstrate lower income for purposes of
1316 obtaining a form of health insurance coverage that imposes fewer costs
1317 on the enrollee.

1318 (3) Individuals who are enrolled in health insurance coverage and
1319 charged premiums for such coverage in accordance with the
1320 provisions of this subsection shall be provided notice of a final
1321 opportunity to opt out of such coverage. Such notice shall be included
1322 with the initial health insurance premium invoice, and shall include
1323 clear and conspicuous notice of the individual's final opportunity to
1324 opt out of health insurance coverage. Individuals who elect to opt out
1325 of health insurance coverage under the provisions of this subdivision
1326 shall do so not later than fifty days after the date on the initial
1327 premium invoice; or in the case of an individual who successfully
1328 demonstrates that he or she did not receive the initial mailed premium
1329 invoice, not later than thirty days after the date of actual receipt of the
1330 initial health insurance premium invoice. An individual opting out of
1331 health insurance coverage pursuant to this subdivision shall be
1332 disenrolled from such coverage, and the authority shall waive any
1333 claim of past due premiums from such individual. If necessary to
1334 protect the individual's credit rating, the authority shall inform
1335 applicable credit agencies that no debt is owed from such individual.

1336 (e) The board shall ensure that any individual, who is determined to
1337 be uninsured pursuant to subsections (b) and (f) of this section, shall be
1338 provided written information concerning the potential risks associated
1339 with the lack of health insurance coverage. The content of such written
1340 information shall be consistent with guidelines developed by the
1341 board. The board may also require such individuals to attend a
1342 presentation by the board on the potential risks associated with the
1343 lack of health insurance coverage. After being provided with such
1344 information, if the individual wishes to remain uninsured, the
1345 individual shall execute a signed writing, in such form as the board
1346 may prescribe, indicating that such individual, after being informed of
1347 the potential risks associated with the lack of health insurance
1348 coverage, has voluntarily elected to remain uninsured. An individual's
1349 decision to remain uninsured shall be effective for a period of time not
1350 to exceed one year from the date of executing the signed writing. Such
1351 decision to remain uninsured shall be renewed for subsequent one-

1352 year periods, using the informed consent procedures set forth in this
1353 subsection. Information required pursuant to this subsection shall be
1354 provided in multiple languages, as needed, to ensure that an
1355 individual fully comprehends the ramifications of electing to remain
1356 uninsured.

1357 (f) An individual who lacks access to employer-sponsored insurance
1358 shall be enrolled in the Sustinet Plan. The board shall provide
1359 immediate post-enrollment outreach to such individual that includes
1360 the scope of coverage, premium obligations, if any, and the ability to
1361 voluntarily opt out of health insurance coverage, as set forth in
1362 subsections (d) and (e) of this section. Information required pursuant
1363 to this subsection shall be provided in multiple languages, as needed,
1364 to ensure that an individual fully comprehends the benefits available
1365 under the Sustinet Plan and the ramifications of electing to remain
1366 uninsured.

1367 (g) An individual with access to employer-sponsored insurance
1368 shall enroll in such employer-sponsored insurance, unless such
1369 individual elects to enroll in the Sustinet Plan pursuant to the
1370 provisions of subsection (d) of section 9 of this act or such individual
1371 chooses to remain uninsured consistent with the procedures set forth
1372 in subsections (d) and (e) of this section.

1373 (h) The board shall develop and implement a plan that ensures that
1374 the enrollment procedures set forth in this section begin on July 1,
1375 2011, and shall be phased in to operate state-wide by July 1, 2014. The
1376 board shall develop an appropriate phase-in strategy, that may be
1377 based on geography and that allows for strategy modification on an as
1378 needed basis.

1379 Sec. 19. Section 17b-297b of the general statutes is repealed and the
1380 following is substituted in lieu thereof (*Effective July 1, 2011*):

1381 (a) To the extent permitted by federal law, the Commissioners of
1382 Social Services and Education, in consultation with the board of
1383 directors of the Sustinet Authority established pursuant to section 2 of

1384 this act, shall jointly establish procedures for the sharing of
1385 information contained in applications for free and reduced price meals
1386 under the National School Lunch Program for the purpose of
1387 determining whether children participating in said program are
1388 eligible for coverage under the SustiNet Plan or the HUSKY Plan, Part
1389 A and Part B. The Commissioner of Social Services shall take all
1390 actions necessary to ensure that children identified as eligible for
1391 [either] SustiNet Plan, or the HUSKY Plan, Part A or Part B, are
1392 enrolled in the appropriate plan.

1393 (b) The Commissioner of Education shall establish procedures
1394 whereby an individual may apply for the SustiNet Plan or the HUSKY
1395 Plan, Part A or Part B, at the same time such individual applies for the
1396 National School Lunch Program.

1397 Sec. 20. (NEW) (*Effective July 1, 2011*) (a) The board, in collaboration
1398 with the Department of Social Services, shall ensure that the
1399 application and information retention process for the HUSKY Plan,
1400 Part A and Part B and for SustiNet premium subsidies is convenient
1401 and consumer-friendly. Such application and information retention
1402 process shall safeguard individual privacy and be designed and
1403 administered in a manner that is consistent with obtaining federal
1404 matching funds for the benefit of those who qualify for health
1405 insurance coverage under the provisions of this section and sections 1
1406 to 18, inclusive, and section 21 of this act.

1407 (b) Individual assets shall not be a factor in determining eligibility
1408 for HUSKY Plan, Part A or Part B or SustiNet premium subsidies.

1409 (c) To the extent permitted by federal law, eligibility for HUSKY
1410 Plan, Part A and Part B and SustiNet premium subsidies shall be
1411 certified for twelve-month periods, based on information available at
1412 the time of application. Changes in household circumstances during
1413 that year shall not affect eligibility, except that an enrollee may qualify
1414 for less costly coverage or coverage that includes additional benefits if
1415 such enrollee satisfactorily demonstrates reduced income, lost health

1416 insurance coverage or other relevant changes in household
1417 circumstances since the time of application.

1418 (d) The Department of Social Services, when determining the
1419 proportion of individuals who are enrolled in the HUSKY Plan, Part A
1420 and Part B or who receive SustiNet premium subsidies and who are
1421 eligible for federal matching funds based on immigration status, shall,
1422 to the extent permitted by federal law, (1) claim matching funds based
1423 on statistically valid caseload samples rather than individual
1424 applications that provide evidence of their immigration status; and (2)
1425 document applicant citizenship and immigration status whenever
1426 possible through data matches with federal authorities, rather than
1427 requiring applicants to provide copies of relevant documents.

1428 (e) The Department of Social Services, when redetermining
1429 eligibility for the HUSKY Plan, Part A and Part B, and for SustiNet
1430 premium subsidies, shall minimize procedural terminations of benefits
1431 through the use of administrative renewals, ex parte renewals and
1432 telephonic renewals.

1433 Sec. 21. (NEW) (*Effective July 1, 2009*) (a) The board shall retain
1434 discretion to revise the policies and practices set forth in sections 3 to 8,
1435 inclusive, of this act, concerning the operation and administration of
1436 the health care delivery system serving SustiNet members. Policy and
1437 practice revisions shall be based on best practices and emergent
1438 evidence concerning improvements to the health care delivery system.

1439 (b) The board shall conduct an ongoing examination of the use of
1440 electronic health records and other data to identify outstanding
1441 practices that would improve quality and value of care provided to
1442 SustiNet Plan members. Such examination shall include analysis of the
1443 factors that lead to outstanding performance by particular providers
1444 and incorporating such factors into the SustiNet Plan. The board shall
1445 also use electronic health records to evaluate the comparative
1446 effectiveness of alternative treatments, weighing both the benefits and
1447 risks of such alternative treatments. The board may collaborate with

1448 other in-state and out-of-state entities undertaking similar efforts.

1449 (c) The board shall regularly evaluate member success in obtaining
1450 health insurance coverage, accessing care and experiencing positive
1451 health outcomes. The board shall revise policies and practices when
1452 necessary to improve care for members as a whole or for vulnerable
1453 subsets of the entire SustiNet Plan membership. Subjects that the board
1454 shall regularly evaluate shall include, but not be limited to: (1) The
1455 application and enrollment process; (2) access to, utilization of, and
1456 quality of healthcare; (3) overall health status; and (4) the effectiveness
1457 of any policies and practice that are revised pursuant to this subsection
1458 or subsection (a) of this section.

1459 (d) If, in the judgment of the board, the SustiNet Plan is causing a
1460 significant shift of costs from employers to consumers or to the public
1461 sector, the board, in consultation with the Department of Social
1462 Services, may modify SustiNet Plan coverage, including eligibility for
1463 SustiNet premium subsidies and adult coverage offered through the
1464 HUSKY Plan, Part B, to remedy such cost shift, except that no
1465 eligibility or other restriction may be imposed on individuals who
1466 would have qualified for state-sponsored health insurance coverage
1467 under state law that was in effect on January 1, 2009.

1468 (e) If, in the judgment of the board, the SustiNet Plan is experiencing
1469 significant harm as the result of adverse selection by individuals or
1470 employers, the board may revise the terms and conditions of
1471 enrollment into the SustiNet Plan.

1472 (f) If, in the judgment of the board, significant numbers of
1473 uninsured residents are being deterred from enrolling into the
1474 SustiNet Plan by the cost of premiums, the board may increase
1475 premium subsidies to reduce such costs.

1476 (g) If, in the judgment of the board, significant numbers of people
1477 without access to SustiNet Plan coverage are receiving employer-
1478 sponsored insurance that does not provide affordable access to the full
1479 range of necessary health care, the board may revise the circumstances

1480 under which individuals offered employer-sponsored insurance may
1481 enroll in the Sustinet Plan.

1482 (h) Prior to the board implementing a policy revision as set forth in
1483 this section, the board shall conduct a public hearing to obtain input on
1484 the proposed policy revision. The board shall ensure that not less than
1485 thirty days notice of such public hearing is provided to the public, by
1486 publication in not less than three newspapers having a substantial
1487 circulation in the state, to the board's appointing authorities, by
1488 publication on the authority's web site, and to the joint standing
1489 committees of the General Assembly having cognizance of matters
1490 relating to public health, human services, labor and public employees,
1491 appropriations and the budgets of state agencies and finance, revenue
1492 and bonding.

1493 (i) The board shall monitor the federal law, regulations and policy
1494 relevant to the implementation of sections 1 to 18, inclusive, 20 to 22,
1495 inclusive, and 24 to 26, inclusive, of this act. In order to optimally
1496 position the state to benefit from changes to federal law, regulation
1497 and policy, the board: (1) May, to the extent permitted by this act and
1498 other applicable state and federal law, modify board regulations,
1499 policies and guidelines to conform to changes in federal law, and (2)
1500 shall promptly make recommendations to the General Assembly for
1501 any necessary or advisable changes to this act or other provisions of
1502 state law.

1503 Sec. 22. (NEW) (*Effective July 1, 2009*) (a) On or before December 1,
1504 2010, and annually thereafter, the authority shall report, in accordance
1505 with the provisions of section 11-4a of the general statutes, to the
1506 appointing authorities of the board of directors and to the joint
1507 standing committees of the General Assembly having cognizance of
1508 matters relating to public health, human services, labor and public
1509 employees, appropriations and the budgets of state agencies and
1510 finance, revenue and bonding on the status of health care in the state.
1511 Such report shall include information on the status of health care in
1512 this state in general, as well as, the design and implementation of the

1513 SustiNet Plan. The report shall include recommendations for
1514 legislative changes that should be made concerning the administration
1515 of the SustiNet Plan.

1516 (b) Each report filed on or after December 1, 2011, shall include:

1517 (1) General trends in coverage, health outcomes, quality and access
1518 for SustiNet Plan members;

1519 (2) Health care provider workforce issues;

1520 (3) The extent to which employer-sponsored health insurance
1521 coverage provides affordable access to necessary health care for
1522 employees and their dependents, including those with low incomes
1523 and health problems, along with policy options for addressing any
1524 problems identified; and

1525 (4) Whether provider networks are sufficient to furnish all SustiNet
1526 Plan members with excellent access to care and, to the extent that any
1527 members lack such access, proposals that remedy this deficiency.

1528 (c) Each report filed on or after December 1, 2012, shall include:

1529 (1) Recommendations as to whether SustiNet Plan coverage should
1530 be extended to serve Medicare enrollees who are not state retirees, and
1531 if so, the extent of such coverage;

1532 (2) A recommendation as to whether SustiNet Plan coverage should
1533 be extended to serve Medicaid enrollees who are not enrolled in the
1534 SustiNet Plan due to age or disability, and if so, the extent and nature
1535 of such coverage;

1536 (3) Whether implementation of the SustiNet Plan has caused a shift
1537 of costs from employers to taxpayers, and if so, proposals to remedy
1538 such cost shift; and

1539 (4) Whether additional changes to individual market regulation are
1540 needed.

1541 (d) Each report filed on or after December 1, 2012, shall indicate
1542 whether shared responsibility payments should be modified to reflect
1543 an employer's ability to pay based on size, wage level, industry and
1544 other factors.

1545 (e) Each report filed on or after December 1, 2013, shall indicate
1546 whether deficits or excesses in the physical infrastructure of the health
1547 care system are increasing health care costs without yielding
1548 corresponding gains in patient health outcomes, and if so, proposals to
1549 remedy such deficits or excesses.

1550 (f) Each report filed on or after December 1, 2014, shall address the
1551 effectiveness of the state's voluntary system of providing health care
1552 coverage to all state residents, including those who are young and
1553 healthy, and the advantages and disadvantages of changing state law
1554 to mandate each resident to obtain coverage.

1555 Sec. 23. Subdivision (1) of section 1-120 of the general statutes is
1556 repealed and the following is substituted in lieu thereof (*Effective July*
1557 *1, 2009*):

1558 (1) "Quasi-public agency" means the Connecticut Development
1559 Authority, Connecticut Innovations, Incorporated, Connecticut Health
1560 and Educational Facilities Authority, Connecticut Higher Education
1561 Supplemental Loan Authority, Connecticut Housing Finance
1562 Authority, Connecticut Housing Authority, Connecticut Resources
1563 Recovery Authority, Capital City Economic Development Authority,
1564 [and] Connecticut Lottery Corporation and the Sustinet Authority.

1565 Sec. 24. (NEW) (*Effective July 1, 2009*) The state shall protect, save
1566 harmless and indemnify the Sustinet Authority and its directors,
1567 officers, contractors and employees from financial loss and expense,
1568 including legal fees and costs, if any, arising out of any claim, demand,
1569 suit or judgment based upon any alleged act or omission of the
1570 authority or any such director, officer, contractor or employee in
1571 connection with, or any other legal challenge to, the Sustinet Plan, as
1572 defined section 1 of this act, provided any such director, officer,

1573 contractor or employee is found to have been acting in the discharge of
1574 such director, officer, contractor or employee's duties or within the
1575 scope of such director, officer, contractor or employee's employment
1576 and any such act or omission is found not to have been wanton,
1577 reckless, wilful or malicious.

1578 Sec. 25. (NEW) (*Effective July 1, 2009*) Notwithstanding any other
1579 provision of state law, no state court shall have jurisdiction to hear a
1580 claim that any provision of sections 1 to 18, inclusive, 20 to 22,
1581 inclusive, 24 to 26, inclusive, of this act, violates the Employee
1582 Retirement Income Security Act of 1974.

1583 Sec. 26. (NEW) (*Effective July 1, 2009*) If any of the provisions of
1584 sections 1 to 18, inclusive, 20 to 22, inclusive, 24 to 25, inclusive, of this
1585 act, or the applicability or enforceability thereof is held invalid by any
1586 court of competent jurisdiction, the remainder of the provisions of said
1587 sections shall not be affected thereby.

1588 Sec. 27. (*Effective from passage*) (a) There is established a task force to
1589 study childhood and adult obesity. The task force shall examine
1590 evidence-based strategies for preventing and reducing obesity in
1591 children and adults and develop a comprehensive plan that will
1592 effectuate a reduction in obesity among children and adults.

1593 (b) The task force shall consist of the following members:

1594 (1) One appointed by the speaker of the House of Representatives,
1595 who shall represent a consumer group with expertise in childhood and
1596 adult obesity;

1597 (2) One appointed by the president pro tempore of the Senate, who
1598 shall be an academic expert in childhood and adult obesity;

1599 (3) One appointed by the majority leader of the House of
1600 Representatives, who shall be a representative of the business
1601 community with expertise in childhood and adult obesity;

1602 (4) One appointed by the majority leader of the Senate, who shall be

1603 a health care practitioner with expertise in childhood and adult
1604 obesity;

1605 (5) One appointed by the minority leader of the House of
1606 Representatives, who shall be a representative of the business
1607 community with expertise in childhood and adult obesity;

1608 (6) One appointed by the minority leader of the Senate, who shall be
1609 a health care practitioner with expertise in childhood and adult
1610 obesity;

1611 (7) One appointed by the Governor who shall be an academic expert
1612 in childhood and adult obesity; and

1613 (8) The Commissioners of Public Health, Social Services and
1614 Economic and Community Development and a representative of the
1615 Sustinet board of directors shall be ex-officio, nonvoting members of
1616 the task force.

1617 (c) Any member of the task force appointed under subdivision (1),
1618 (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member
1619 of the General Assembly.

1620 (d) All appointments to the task force shall be made no later than
1621 thirty days after the effective date of this section. Any vacancy shall be
1622 filled by the appointing authority.

1623 (e) The members of the task force appointed by the speaker of the
1624 House of Representatives and the president pro tempore of the Senate
1625 shall serve as the chairpersons of the task force. Such chairpersons
1626 shall schedule the first meeting of the task force, which shall be held no
1627 later than thirty days after the effective date of this section.

1628 (f) The administrative staff of the joint standing committee of the
1629 General Assembly having cognizance of matters relating to public
1630 health shall serve as administrative staff of the task force.

1631 (g) Not later than July 1, 2010, the task force shall submit a report on

1632 its findings and recommendations to the joint standing committee of
1633 the General Assembly having cognizance of matters relating to public
1634 health, human services and appropriations and the budgets of state
1635 agencies in accordance with the provisions of section 11-4a of the
1636 general statutes. The task force shall terminate on the date that it
1637 submits such report or January 1, 2011, whichever is later.

1638 Sec. 28. (*Effective from passage*) (a) There is established a task force to
1639 study tobacco use by children and adults. The task force shall examine
1640 evidence-based strategies for preventing and reducing tobacco use by
1641 children and adults, and then develop a comprehensive plan that will
1642 effectuate a reduction in tobacco use by children and adults.

1643 (b) The task force shall consist of the following members:

1644 (1) One appointed by the speaker of the House of Representatives,
1645 who shall represent a consumer group with expertise in tobacco use by
1646 children and adults;

1647 (2) One appointed by the president pro tempore of the Senate, who
1648 shall be an academic expert in tobacco use by children and adults;

1649 (3) One appointed by the majority leader of the House of
1650 Representatives, who shall be a representative of the business
1651 community with expertise in tobacco use by children and adults;

1652 (4) One appointed by the majority leader of the Senate, who shall be
1653 a health care practitioner with expertise in tobacco use by children and
1654 adults;

1655 (5) One appointed by the minority leader of the House of
1656 Representatives, who shall be a representative of the business
1657 community with expertise in tobacco use by children and adults;

1658 (6) One appointed by the minority leader of the Senate, who shall be
1659 a health care practitioner with expertise in tobacco use by children and
1660 adults;

1661 (7) One appointed by the Governor who shall be an academic expert
1662 in tobacco use by children and adults; and

1663 (8) The Commissioners of Public Health, Social Services and
1664 Economic and Community Development and a representative of the
1665 SustiNet board of directors shall be ex-officio, nonvoting members of
1666 the task force.

1667 (c) Any member of the task force appointed under subdivision (1),
1668 (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member
1669 of the General Assembly.

1670 (d) All appointments to the task force shall be made no later than
1671 thirty days after the effective date of this section. Any vacancy shall be
1672 filled by the appointing authority.

1673 (e) The members of the task force appointed by the speaker of the
1674 House of Representatives and the president pro tempore of the Senate
1675 shall serve as the chairpersons of the task force. Such chairpersons
1676 shall schedule the first meeting of the task force, which shall be held no
1677 later than thirty days after the effective date of this section.

1678 (f) The administrative staff of the joint standing committee of the
1679 General Assembly having cognizance of matters relating to public
1680 health shall serve as administrative staff of the task force.

1681 (g) Not later than July 1, 2010, the task force shall submit a report on
1682 its findings and recommendations to the joint standing committee of
1683 the General Assembly having cognizance of matters relating to public
1684 health, human services and appropriations and the budgets of state
1685 agencies in accordance with the provisions of section 11-4a of the
1686 general statutes. The task force shall terminate on the date that it
1687 submits such report or January 1, 2011, whichever is later.

1688 Sec. 29. (*Effective from passage*) (a) There is established a task force to
1689 study the state's health care workforce. The task force shall develop a
1690 comprehensive plan for preventing and remedying state-wide,

1691 regional and local shortage of necessary medical personnel.

1692 (b) The task force shall consist of the following members:

1693 (1) One appointed by the speaker of the House of Representatives,
1694 who shall represent a consumer group with expertise in health care;

1695 (2) One appointed by the president pro tempore of the Senate, who
1696 shall be an academic expert on the health care workforce;

1697 (3) One appointed by the majority leader of the House of
1698 Representatives, who shall be a representative of the business
1699 community with expertise in health care;

1700 (4) One appointed by the majority leader of the Senate, who shall be
1701 a health care practitioner;

1702 (5) One appointed by the minority leader of the House of
1703 Representatives, who shall be a representative of the business
1704 community with expertise in health care;

1705 (6) One appointed by the minority leader of the Senate, who shall be
1706 a health care practitioner;

1707 (7) One appointed by the Governor who shall be an academic expert
1708 in health care; and

1709 (8) The Commissioners of Public Health, Social Services and
1710 Economic and Community Development, the president of The
1711 University of Connecticut, the chancellor of the Connecticut State
1712 University System, the chancellor of the Regional Community-
1713 Technical Colleges, and a representative of the SustiNet board of
1714 directors shall be ex-officio, nonvoting members of the task force.

1715 (c) Any member of the task force appointed under subdivision (1),
1716 (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member
1717 of the General Assembly.

1718 (d) All appointments to the task force shall be made no later than

1719 thirty days after the effective date of this section. Any vacancy shall be
 1720 filled by the appointing authority.

1721 (e) The members of the task force appointed by the speaker of the
 1722 House of Representatives and the president pro tempore of the Senate
 1723 shall serve as the chairpersons of the task force. Such chairpersons
 1724 shall schedule the first meeting of the task force, which shall be held no
 1725 later than thirty days after the effective date of this section.

1726 (f) The administrative staff of the joint standing committee of the
 1727 General Assembly having cognizance of matters relating to public
 1728 health shall serve as administrative staff of the task force.

1729 (g) Not later than July 1, 2010, the task force shall submit a report on
 1730 its findings and recommendations to the joint standing committee of
 1731 the General Assembly having cognizance of matters relating to public
 1732 health, human services and appropriations and the budgets of state
 1733 agencies in accordance with the provisions of section 11-4a of the
 1734 general statutes. The task force shall terminate on the date that it
 1735 submits such report or January 1, 2011, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2009</i>	New section
Sec. 2	<i>July 1, 2009</i>	New section
Sec. 3	<i>July 1, 2009</i>	New section
Sec. 4	<i>July 1, 2009</i>	New section
Sec. 5	<i>July 1, 2009</i>	New section
Sec. 6	<i>July 1, 2009</i>	New section
Sec. 7	<i>July 1, 2009</i>	New section
Sec. 8	<i>July 1, 2009</i>	New section
Sec. 9	<i>July 1, 2009</i>	New section
Sec. 10	<i>July 1, 2009</i>	New section
Sec. 11	<i>July 1, 2009</i>	New section
Sec. 12	<i>July 1, 2009</i>	New section
Sec. 13	<i>July 1, 2009</i>	New section
Sec. 14	<i>July 1, 2009</i>	New section
Sec. 15	<i>July 1, 2009</i>	New section

Sec. 16	<i>July 1, 2009</i>	New section
Sec. 17	<i>July 1, 2009</i>	New section
Sec. 18	<i>July 1, 2009</i>	New section
Sec. 19	<i>July 1, 2011</i>	17b-297b
Sec. 20	<i>July 1, 2011</i>	New section
Sec. 21	<i>July 1, 2009</i>	New section
Sec. 22	<i>July 1, 2009</i>	New section
Sec. 23	<i>July 1, 2009</i>	1-120(1)
Sec. 24	<i>July 1, 2009</i>	New section
Sec. 25	<i>July 1, 2009</i>	New section
Sec. 26	<i>July 1, 2009</i>	New section
Sec. 27	<i>from passage</i>	New section
Sec. 28	<i>from passage</i>	New section
Sec. 29	<i>from passage</i>	New section

PH *Joint Favorable Subst.*

HS *Joint Favorable*