General Assembly

Substitute Bill No. 6600

January Session, 2009

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AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

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

Section 1. (NEW) (*Effective July 1, 2009*) As used in sections 1 to 16, inclusive, of this act and section 17b-297b of the general statutes, as amended by this act:

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

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

(A) Coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical and occupational therapy; home health care; vision care; family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; the identification and treatment of developmental

delays from birth through age three; and wellness programs, provided the public authority approves such wellness programs after being presented with convincing scientific evidence that such programs are effective in reducing the severity or incidence of chronic disease;

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

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

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

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

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

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

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

(4) "Electronic health record" means an electronic record of health-related information on an individual that conforms to nationally

recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization;

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

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

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

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

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

who shall be a representative of the Connecticut Nurses' Association; and one appointed by the minority leader of the House of Representatives, who shall be a representative of private employers; two appointed by the coalition committee established pursuant to subsection (f) of section 5-278 of the general statutes, one of whom shall be a representative of labor unions and one of whom shall be a representative of business management. In addition, the Commissioners of Social Services, Public Health and Mental Health and Addiction Services and the Insurance Commissioner shall be ex-officio, nonvoting members of the board of directors. The Comptroller and the Healthcare Advocate, or their designees, shall serve as the chairpersons of the board of directors.

(b) Initial appointments to the board of directors shall be made on or before July 15, 2009. In the event that an appointing authority fails to appoint a board member by July 15, 2009, the president pro tempore of the Senate and the speaker of the House of Representatives shall jointly appoint a board member meeting the required specifications on behalf of such appointing authority and such board member shall serve a full term. The presence of not less than seven members shall constitute a quorum for the transaction of business. The initial term for the board members appointed by the Governor, Lieutenant Governor and the president pro tempore of the Senate shall be for two years. The initial term for board members appointed by the speaker of the House of Representatives and the majority leader of the Senate shall be for three years. The initial term for board members appointed by the majority leader of the House of Representatives and the minority leader of the Senate shall be for four years. The initial term for the board member appointed by the minority leader of the House of Representatives shall be for five years. Terms pursuant to this subdivision shall expire on June thirtieth in accordance with the provisions of this subdivision. Not later than thirty days prior to the expiration of a term as provided for in this subsection, the appointing authority may reappoint the current board member or shall appoint a new member to the board. Other than an initial term, a board member

shall serve for a term of five years and until a successor board member is appointed. A member of the board pursuant to this subdivision shall be eligible for reappointment. Any member of the board may be removed by the appropriate appointing authority for misfeasance, malfeasance or wilful neglect of duty.

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

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

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

(c) The SustiNet Health Partnership board of directors shall offer recommendations on matters that include, but are not limited to, the establishment of a public authority authorized and empowered:

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

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

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

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

(5) To adopt guidelines, policies and regulations in accordance with chapter 54 of the general statutes that are necessary to implement the provisions of this section and sections 1 to 16, inclusive, of this act;

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

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

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

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

outside the state's borders;

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

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

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

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

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

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

(16) To set payment methods for providers that reflect evolving research and experience both within the state and elsewhere, promote patient health, prevent unnecessary spending, and ensure sufficient

compensation to cover the reasonable cost of furnishing necessary care;

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

(18) To arrange the offering of reduced price consultants that shall assist physicians and other health care providers in restructuring their practices and offices so as to function more effectively and efficiently in response to changes in health care insurance coverage and the health care service delivery system that are attributable to the implementation of the SustiNet Plan;

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

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

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

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

(23) To make optimum use of opportunities created by the federal government for securing new and increased federal funding,

including, but not limited to, increased reimbursement revenues;

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

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

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

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

(b) The board of directors shall identify all potential funding sources that may be utilized to establish and administer the SustiNet Plan and such funding sources shall be included in the report prepared pursuant to subsection (d) of this section.

(c) The board of directors shall recommend that the public authority adopt periodic action plans to achieve measurable objectives in areas that include, but are not limited to, effective management of chronic illness, preventive care, reducing racial and ethnic disparities as related to health care and health outcomes, and reducing the number

of state residents without insurance. The board of directors shall include in its recommendations that the public authority monitor the accomplishment of such objectives and modify action plans as necessary. The public authority's action plans and progress made with respect to achieving the objectives of such plans shall be included in the report prepared pursuant to subsection (d) of this section.

(d) On or before July 1, 2010, and annually thereafter, the board of directors shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, labor and public employees, appropriations and the budgets of state agencies and finance, revenue and bonding on the status of health care in the state, as well as the design and implementation of the SustiNet Plan.

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

(b) The board of directors shall recommend that the public authority: (1) Furnish approved software to subscribing providers and to participating providers, as the case may be, consistent with the capital acquisition, technical support, reduced-cost digitization of records, software updating and software transition procedures described in this section; and (2) develop and implement procedures to ensure that physicians, nurses, hospitals and other health care providers gain access to hardware and approved software for interoperable electronic medical records and the establishment of

electronic health records for SustiNet Plan members.

(c) The board of directors shall establish an information technology committee that shall formulate a plan for developing, acquiring, financing, leasing or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers. Such plan shall include the development of a periodic payment system that allows subscribing providers to acquire approved software and hardware while receiving the services described in this section.

(d) The information technology committee shall consult with health information technology specialists, physicians, nurses, hospitals and other health care providers, as deemed appropriate by the committee, to identify potential software and hardware options that meet the needs of the full array of health care practices in the state. Any electronic medical record package that the committee recommends for future possible purchase shall include, to the maximum extent feasible: (1) A full set of functionalities for pertinent provider categories, including practice management, patient scheduling, claims submission, billing, issuance and tracking of laboratory orders and prescriptions; (2) automated patient reminders concerning upcoming appointments; (3) recommended preventive care services; (4) automated provision of test results to patients, when appropriate; (5) decision support, including a notice of recommended services not yet received by a patient; (6) notice of potentially duplicative tests and other services; (7) in the case of prescriptions, notice of potential interactions with other drugs and past patient adverse reactions to similar medications; (8) notice of possible violation of patient wishes for end-of-life care; (9) notice of services provided inconsistently with care guidelines adopted pursuant to section 8 of this act, along with options that permit the convenient recording of reasons why such guidelines are not being followed; and (10) such additional functions as may be approved by the information technology committee.

(e) The committee shall recommend that any approved software have the capacity to: (1) Gather information pertinent to assessing

health care outcomes, including activity limitations, self-reported health status and other quality of life indicators; and (2) allow the board of directors to track the accomplishment of clinical care objectives at all levels. The board of directors shall ensure that SustiNet Plan providers who use approved software are able to electronically transmit to, and receive information from, all laboratories and pharmacies participating in the SustiNet Plan, without the need to construct interfaces, other than those constructed by the public authority.

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

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

(h) All recommendations concerning electronic medical records and electronic health records shall be developed and administered in a manner that is consistent with board of directors approved guidelines for safeguarding privacy and data security, consistent with state and federal law, including recommendations of the United States Government Accountability Office. Such guidelines shall include the remedies and sanctions that apply in the event of a provider's failure to

comply with privacy or information security requirements. Remedies shall include notice to affected members and may include, in appropriate cases, termination of network privileges and denial or reduction of SustiNet Plan reimbursement. Remedies and sanctions recommended by the board of directors shall be in addition to those otherwise available under state or federal law.

(i) The committee shall develop recommended methods to eliminate or minimize transition costs for health care providers that, prior to July 1, 2010, implemented comprehensive systems of electronic medical records or electronic health records. Such methods may include technical assistance in transitioning to new software and development of modules to help existing software connect to the integration system described in subsection (i) of this section.

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

(k) The committee shall recommend that electronic health records be structured to facilitate the provision of medical home functions pursuant to section 6 of this act. The committee shall recommend methods for such electronic health records to generate automatic notices to medical homes that: (1) Report when an enrolled member

receives services outside the medical home; (2) describe member compliance or noncompliance with provider instructions, as relate to the filling of prescriptions, referral services, and recommended tests, screenings or other services; and (3) identify the expiration of refillable prescriptions.

(l) The committee shall recommend that each participating provider use either approved software or other electronic medical record software that is interoperable with approved software and the electronic health record integration system described in subsection (g) of this section. The committee shall develop and implement appropriate financial incentives for early subscriptions by participating providers, including discounted fees for providers who do not delay their subscriptions. The committee shall recommend that no later than July 1, 2015, the board of directors require as a condition of participation in the SustiNet Plan that each participating provider use either approved software or other electronic medical record software that is interoperable with approved software and the electronic health record integration system described in subsection (g) of this section. The committee shall recommend that after July 1, 2015, the board of directors have authority to provide additional support to a provider that demonstrates to the satisfaction of the board that such provider would experience special hardship due to the implementation of electronic medical records and electronic health records requirements within the specified time frame. The committee shall recommend that such provider be allowed to qualify for additional support and an exemption from compliance with the time frame specified in this subsection, but only if such an exemption is necessary to ensure that members in the geographic locality served by the provider continue to receive excellent access to care.

(m) The committee shall recommend methods to coordinate the development and implementation of electronic medical records and electronic health records in concert with the Department of Public Health, the Office of Health Care Access, and other state agencies to ensure efficiency and compatibility. The committee shall determine

appropriate financing options, including, but not limited to, financing through the Connecticut Health and Educational Facilities Authority established pursuant to section 10a-179 of the general statutes.

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

(b) The committee shall recommend that: (1) Medical home functions be defined by the board on an ongoing basis that incorporates evolving research concerning the delivery of health care services; and (2) if limitations in provider infrastructure prevent all SustiNet Plan members from being enrolled in patient-centered medical homes, enrollment in medical homes be implemented in phases with priority enrollment given to members for whom cost savings appear most likely, including, in appropriate cases, members with chronic health conditions.

(c) Subject to revision by the board of directors, the committee shall recommend that initial medical home functions include the following:

(1) Assisting members to safeguard and improve their own health by: (A) Advising members with chronic health conditions of methods to monitor and manage their own conditions; (B) working with members to set and accomplish goals related to exercise, nutrition, use of tobacco and other addictive substances, sleep, and other behaviors that directly affect such member's health; (C) implementing best

practices to ensure that members understand medical instructions and are able to follow such directions; and (D) providing translation services and using culturally competent communication strategies in appropriate cases;

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

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

(d) The committee shall recommend that: (1) A licensed health care provider be allowed to serve as a medical home if such provider is authorized to provide all core medical home functions as prescribed by the board and operationally capable of providing such functions; and (2) a group practice or community health center serving as a medical home identify, for each member, a lead provider with primary responsibility for the member's care. In appropriate cases, as determined by the board of directors, a specialist may serve as a medical home and a patient's medical home may temporarily be with a health care provider who is overseeing the patient's care for the duration of a temporary medical condition, including pregnancy.

(e) The committee shall recommend that: (1) Each medical home provider be presented with a listing of all medical home functions, including patient education, care coordination and twenty-four-hour accessibility; and (2) if a provider does not wish to perform, within his or her office, certain functions outside core medical home functions, such provider, with assistance from the public authority, make arrangements for other qualified entities or individuals to perform such functions, in a manner that integrates such functions into the medical home's clinical practice. Such qualified entities or individuals may be employed by or under contract with the public authority, health care insurers or other individuals or entities and shall be certified by the public authority based on factors that include the quality, safety and efficiency of the services provided. At the request of a core medical home provider, the public authority shall make all necessary arrangements required for a qualified entity or individual to perform any medical home function not assumed by the core provider.

(f) The medical home advisory committee may develop quality and safety standards for medical home functions that are not covered by existing professional standards, which may include care coordination and member education.

(g) The committee shall recommend that the public authority assist in the development of community-based resources to enhance medical home functions, including linguistically and culturally competent member education and care coordination.

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

other steps, as deemed necessary by the board, to make payments that cover the cost of performing each function.

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

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

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

(c) The committee shall recommend quality of care standards for the care of particular medical conditions. Such standards may reflect outcomes over the entire care cycle for each health care condition,

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

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

(e) The board of directors, in consultation with representatives from licensed hospitals, shall develop hospital safety standards that shall be implemented in such hospitals. The board of directors shall establish monitoring procedures and sanctions that ensure compliance by each participating hospital with such safety standards and may establish performance incentives to encourage hospitals to exceed such safety standards.

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

(g) The committee shall recommend that the public authority may develop and implement procedures and incentives that encourage participating providers to furnish and SustiNet Plan members to obtain appropriate evidenced-based health care.

Sec. 8. (NEW) (*Effective July 1, 2009*) (a) The board of directors shall establish a preventive health care committee that shall use evolving medical research to draft recommendations to improve health outcomes for members in areas involving nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances. The committee shall include providers, consumers and other individuals chosen by said board. Such recommendations may be targeted to member populations where they are most likely to have a beneficial impact on the health of such members and may include behavioral components and financial incentives for participants. Such recommendations shall take into account existing preventive care programs administered by the state, including, but not limited to, state administered educational and awareness campaigns. Not later than July 1, 2010, and annually thereafter, the preventative health committee shall submit such recommendations, in accordance with section 11-4a of the general statutes, to the board and to the joint standing committees of the General Assembly having cognizance of matters relating to public health, appropriations and the budgets of state agencies and finance, revenue and bonding. Any recommendation of the committee that does not require legislative action may be presented to the board of directors at any time.

(b) The board of directors shall recommend that the SustiNet Plan provide coverage for community-based preventive care services and such services be required of all health insurance sold pursuant to the plan to individuals or employers. Community-based preventive care services are those services identified by the board as capable of being safely administered in community settings. Such services shall include, but not be limited to, immunizations, simple tests and health care screenings. Such services shall be provided by individuals or entities who satisfy board of director approved standards for quality of care. The board of directors shall recommend that: (1) Prior to furnishing a community-based preventive care service, a provider obtain information from a patient's electronic health record to verify that the service has not been provided in the past and that such services are not contraindicated for the patient; and (2) a provider promptly furnish relevant information about the service and the results of any test or screening to the patient's medical home or the patient's primary care provider if the patient does not have a medical home. The board of directors shall recommend that community-based preventive services be allowed to be provided at job sites, schools or other community locations consistent with said board's guidelines.

Sec. 9. (NEW) (*Effective July 1, 2009*) (a) The board of directors shall develop recommendations that ensure that: (1) On and after July 1, 2011, SustiNet Plan membership is offered, as the form of employer-sponsored insurance furnished by the state, to all state employees and retirees and their dependents who qualify for health insurance coverage under state law, including those who would have qualified under state law as of January 1, 2009; (2) benefits, access to providers and out-of-pocket cost-sharing rules that apply to such members be consistent with all collective bargaining agreements that apply to such members; (3) the coalition committee established pursuant to subsection (f) of section 5-278 of the general statutes retains jurisdiction over policy and practice matters that pertain exclusively to coverage for state employees and retirees; (4) the coalition committee has authority to overrule any decision of the board of directors to the

extent that such decision (A) would apply to state employees, retirees or their dependents; and (B) when compared to governing laws in effect on January 1, 2009, would reduce benefits, increase costs to enrollees, reduce access to care or lower the quality of care provided to individuals described in this subsection; and (5) said board takes no action that impinges on a collective bargaining agreement applicable to state employees and retirees and that such collective bargaining agreement remains in full force and effect unless amended.

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

(c) The board of directors shall make recommendations to ensure that on and after October 1, 2011, state residents who are not offered employer-sponsored insurance and who do not qualify for Medicare are permitted to enroll in the SustiNet Plan.

(d) The board of directors shall make recommendations to provide an option for enrollment into the SustiNet Plan, rather than employer-sponsored insurance, for certain state residents who are offered employer-sponsored insurance. Such recommendations shall include that, on and after July 1, 2011, in order to be eligible for such enrollment option: (1) An individual shall be ineligible for Medicare; and (2) (A) the individual has family income at or below four hundred per cent of the federal poverty level and the employee's share of employer-sponsored insurance premiums exceeds by not less than two per cent of household income, the premium amount the individual would pay for enrolling in SustiNet Plan; (B) an individual's diagnosed health conditions make it highly probable that he or she will incur out-of-pocket costs, which are not covered by employer-sponsored insurance, that exceed seven and one-half per cent of household income; or (C) the actuarial value of the individual's employer-sponsored insurance is less than eighty per cent of the median actuarial value of the health coverage offered by large employers in the Northeast states, as determined by the board of directors. Said board

shall also make recommendations for the establishment of a simplified enrollment procedure for those individuals who demonstrate eligibility to enroll in the SustiNet Plan pursuant to this subsection.

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

(b) The board of directors shall recommend that: (1) The public authority be authorized to use new and existing channels of sale to employers, including public and private purchasing pools, agents and brokers; (2) the public authority be authorized to offer multi-year contracts to employers, offering predictable premiums; (3) policies and procedures be established to ensure that employers can easily and conveniently purchase SustiNet Plan coverage for their workers and dependents, including, but not limited to, participation requirements, timing of enrollment, open enrollment, enrollment length and other subject matters as deemed appropriate by said board; (4) policies and procedures be established to prevent adverse selection and achieve other goals specified by the board; (5) beginning on July 1, 2011, small employers be allowed to purchase SustiNet Plan coverage and that the public authority be allowed to vary premiums based on enrollees' characteristics as permitted for small employer carriers, as defined in subdivision (16) of section 38a-564 of the general statutes; (6) beginning on July 1, 2015, employers that are not small employers be allowed to purchase SustiNet Plan coverage and the public authority be allowed to vary the premiums charged to such employers to prevent adverse selection, taking into account past claims experience, changes in the characteristics of covered employees and dependents since the most recent time period covered by claims data, and other factors approved by the board of directors; and (7) employers purchasing coverage under this section be offered the standard benefits package, provided no such benefit package provide less comprehensive coverage than that described in the model benefits packages adopted pursuant to

section 14 of this act.

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

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

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

(d) Except as provided for in subsection (c) of this section, the clearinghouse shall make public all information provided pursuant to subsection (b) of this section. The clearinghouse shall not disseminate any information that identifies individual patients or providers. The

clearinghouse shall adjust outcomes based on patient risk levels, to the maximum extent possible. The clearinghouse shall make information available in multiple forms and languages, taking into account varying needs for the information and different methods of processing such information.

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

Sec. 12. (NEW) (*Effective July 1, 2011*) (a) To the extent permitted by federal law, the Commissioner of Social Services shall take all steps necessary to ensure that, on and after July 1, 2012, all adults with incomes at or below one hundred eighty-five per cent of the federal poverty level are eligible for enrollment in the HUSKY Plan, Part A, whether or not such adults are the custodial parents or caretaker relatives of minor children.

(b) The Commissioner of Social Services shall, to the extent permitted by federal law, take all steps necessary to ensure that on and after July 1, 2012, eligibility for enrollment in the HUSKY Plan, Part B includes adults with incomes from one hundred eighty-six per cent of the federal poverty level to three hundred per cent of the federal poverty level, inclusive. Such adults shall receive services and be responsible for cost-sharing requirements comparable to those imposed on households with children receiving HUSKY Plan, Part B benefits at the same income level, calculated as a percentage of the federal poverty level, taking into account the differential utilization of and need for services between adults and children. Adult enrollees in the HUSKY Plan, Part B program shall be charged a premium payment that is not less than twice the amount charged to the household of a child enrollee at the same income level, calculated as a percentage of the federal poverty level.

Sec. 13. (NEW) (*Effective July 1, 2009*) Notwithstanding any provision of the general statutes, on an after July 1, 2011, individual health insurance policies may not be sold in the state unless they meet the following requirements: (1) Premiums for such policies may not vary based on individual characteristics, except for the reasons and to the extent that such premiums are permitted to vary for the small group market; and (2) preexisting conditions may not be excluded when issuing such policies, except in circumstances when such exclusion would be permitted if the health insurance policy were for the small group market.

Sec. 14. (NEW) (*Effective July 1, 2009*) (a) Within available appropriations, the Office of the Healthcare Advocate shall develop and update the model benefit packages, based on evolving medical evidence and scientific literature, that make the greatest possible contribution to enrollee health for a premium cost typical of private, employer-sponsored insurance in the Northeast states. Not later than December 1, 2010, and biennially thereafter, the Office of the Healthcare Advocate shall report, in accordance with the provisions of section 11-4a of the general statutes, to the board of directors and to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, labor and public employees, appropriations and the budgets of state agencies and finance, revenue and bonding on the updated model benefit packages.

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

(c) The Office of the Healthcare Advocate shall recommend guidelines for establishing an incentive system that recognizes

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

Sec. 15. (NEW) (*Effective July 1, 2009*) (a) The board of directors shall develop recommendations for public education and outreach campaigns to ensure that state residents are informed about the SustiNet Plan and are encouraged to enroll in the plan.

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

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

Sec. 16. (NEW) (*Effective July 1, 2009*) The board of directors, in collaboration with state and municipal agencies, shall, within available appropriations, develop and implement systematic recommendations to identify uninsured individuals in the state. Such recommendations may include that:

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

(2) The Labor Department modify application forms for initial and continuing claims for unemployment insurance to request information

about health insurance status for the applicant and the applicant's dependents.

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

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

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

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

Sec. 18. (*Effective from passage*) (a) There is established a task force to study childhood and adult obesity. The task force shall examine evidence-based strategies for preventing and reducing obesity in children and adults and develop a comprehensive plan that will effectuate a reduction in obesity among children and adults.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 19. (*Effective from passage*) (a) There is established a task force to study tobacco use by children and adults. The task force shall examine evidence-based strategies for preventing and reducing tobacco use by children and adults, and then develop a comprehensive plan that will effectuate a reduction in tobacco use by children and adults.

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

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

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

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

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

a health care practitioner with expertise in tobacco use by children and adults;

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

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

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

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

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

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

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

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

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

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

Sec. 20. (*Effective from passage*) (a) There is established a task force to study the state's health care workforce. The task force shall develop a comprehensive plan for preventing and remedying state-wide, regional and local shortage of necessary medical personnel.

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

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

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

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

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

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

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

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

(8) The Commissioners of Public Health, Social Services and

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

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

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

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	New section
Sec. 2	*July 1, 2009*	New section
Sec. 3	*July 1, 2009*	New section

Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	New section
Sec. 6	*July 1, 2009*	New section
Sec. 7	*July 1, 2009*	New section
Sec. 8	*July 1, 2009*	New section
Sec. 9	*July 1, 2009*	New section
Sec. 10	*July 1, 2009*	New section
Sec. 11	*July 1, 2009*	New section
Sec. 12	*July 1, 2011*	New section
Sec. 13	*July 1, 2009*	New section
Sec. 14	*July 1, 2009*	New section
Sec. 15	*July 1, 2009*	New section
Sec. 16	*July 1, 2009*	New section
Sec. 17	*July 1, 2011*	17b-297b
Sec. 18	*from passage*	New section
Sec. 19	*from passage*	New section
Sec. 20	*from passage*	New section

INS *Joint Favorable Subst.*