Health Insurance Reform and Connecticut

Had we done nothing, by 2019 the number of uninsured people would have grown by more than 30 percent in 29 states and by at least 10 percent in every state. The amount of uncompensated care provided would more than double in 45 states. Businesses in 27 states will see their premiums more than double. And fewer people would have coverage through an employer.[1] In addition to families and businesses struggling with high health care costs, state governments have really felt the burden.

The new law expands coverage to millions of Americans, reduces premiums and out-of-picket costs, and provides the security of knowing that if you lose your job, change your job, or start that new business, you'll always be able to purchase quality, affordable care in a new competitive health insurance market that keeps costs down.

Under reform in Connecticut:

- 356,000 residents who do not currently have insurance and 154,000 residents who have nongroup insurance could get affordable coverage through the health insurance exchange.
- 242,000 residents could qualify for premium tax credits to help them purchase health coverage.
- 547,000 seniors would receive free preventive services.
- 97,100 seniors would have their brand-name drug costs in the Medicare Part D "doughnut hole" halved.
- 37,600 small businesses could be helped by a small business tax credit to make premiums more affordable.

Health Insurance Reform Provides Early Relief and Health Security.
Proposals implemented in 2010 and 2011 will produce ***real benefits*** for:

- **Families:** The 3.5 million residents of Connecticut will benefit as reform:
  - **Ensures consumer protections in the insurance market.** Insurance companies will no longer be able to place lifetime limits on the coverage they provide, use of annual limits will be restricted, and they will not be able to arbitrarily drop coverage.
  - **Creates immediate options for people who can't get insurance today.** 7 percent of people in Connecticut have diabetes[2], and 26 percent have high blood pressure[3] - two conditions that insurance companies could use as a reason to deny health insurance coverage. Reform will establish a high-risk pool to enable people who cannot get insurance today to find an affordable health plan.
  - **Ensures free preventive services.** 30 percent of Connecticut residents have not had a colorectal cancer screening, and 15 percent of women over 50 have not had a mammogram in the past two years.[4] Health insurance reform will ensure that people can access preventive services for free through their health plans. It will also invest in a prevention and public health fund to encourage prevention and wellness programs.
  - **Supports health coverage for early retirees.** An estimated 50,300 people from Connecticut have early retiree coverage through their former employers, but early retiree coverage has eroded over time.[5] A reinsurance program would stabilize early retiree coverage and provide premium relief to both early retirees and the workers in the firms that provide their health benefits. This could save families up to $1,200 on premiums.
- **Seniors:** Connecticut's 547,000 Medicare beneficiaries[6] will benefit as reform:
  - **Lowers premiums by reducing Medicare's overpayments to private plans.** *All* Medicare beneficiaries pay the price of excessive overpayments through higher premiums - even the 85 percent of seniors in Connecticut who are not enrolled in a Medicare Advantage plan.[7] A typical couple in traditional Medicare will pay nearly $90 in additional Medicare premiums next year to subsidize these private plans.[8] Health insurance reform clamps down on these excessive payments.
  - **Reduces prescription drug spending.** Roughly 97,100 Medicare beneficiaries in Connecticut hit the "doughnut hole," or gap in Medicare Part D drug coverage that can cost some seniors an average of $4,080 per year.[9] Reform legislation will provide a 50 percent discount for brand-name drugs in this coverage gap.
  - **Covers free preventive services.** Currently, seniors in Medicare must pay part of the cost of many preventive services on their own. For a colonoscopy that costs $792, this means that a senior must pay $186[10] - a price that can be prohibitively expensive. Under reform, a senior will not pay anything for that colonoscopy, or for any other recommended preventive service. A senior will also get free annual wellness visits to his or her provider, with a personalized prevention plan to remain in good health.
- **Small businesses:** While small businesses make up 76 percent of Connecticut's businesses, only 53 percent of them offered health coverage benefits in 2008.[11] 37,600 small businesses in Connecticut could be helped by a small businesses tax credit proposal that makes premiums more affordable.[12] And these small businesses would be exempt from any employer responsibility provisions.
- **States:** State budgets will be relieved from rising health care costs as reform:
  - **Reduces state employee premiums.** Coverage would immediately be expanded to the uninsured, decreasing the amount of uncompensated care costs that gets shifted to the premiums of state employees. For states that provide early retiree health benefits to their state employees, a reinsurance program would provide premium relief of up to $1,200 per family policy per year for all employees.
  - **Reduces uncompensated care.** Right now, providers in Connecticut lose $383 million in uncompensated care each year,[13] which states subsidize at least in part. Instead, under reform, uncompensated care would begin to be reduced immediately as more uninsured people gain coverage.

Health Insurance Reform Provides Stability, Security, and Choice.

- **Provides relief from rising health care costs.**
  - **Ends the "hidden tax".** The $383 million spent on uncompensated care in Connecticut often gets passed along to families in the form of a hidden premium "tax".[14] By expanding coverage to the uninsured, health insurance reform will eliminate this burden

on people who already have insurance.

- **Provides premium tax credits.** Without reform, individuals and families in Connecticut will spend increasing amounts of money out-of-pocket to cover premiums, deductibles, and co-payments, from $4.5 billion today to up to $7.4 billion in 2019.[15] Through health insurance reform, 242,000 Connecticut residents could be eligible for premium credits to ease the burden of these high costs.[16]

- **Promotes health insurance portability and choice.** Health insurance reform establishes a health insurance exchange that will provide individuals with a wide variety of choices and ensure that they will always have coverage, whether they change jobs, lose a job, move or get sick.
  - Currently 356,000 residents of Connecticut do not have health insurance, and if nothing is done, by 2019 this population could swell to 479,000. The exchange will help the uninsured to obtain needed coverage and will also help the 154,000 Connecticut residents who currently purchase insurance in the individual insurance market to get quality coverage at an affordable price.[17]

- **Supports long-term home and community based services:** It is estimated that 65 percent of those who are 65 today will spend some time at home in need of long-term care services,[18] which typically cost almost $18,000 per year.[19] This means that 255,000 older residents of Connecticut who are aged 55 to 64 today will need home health services after they turn 65[20] - services that are not always covered by Medicare, Medicaid, or private health insurance.
  - Health insurance reform will create a new voluntary long-term care services insurance program, which will provide a cash benefit to help seniors and people with disabilities obtain services and supports that will enable them to remain in their homes and communities.
  - Reform will encourage states to expand their home and community based services through Medicaid by providing enhanced funding, and it will create a program to provide community support services for disabled Medicaid enrollees who would otherwise need to be in a nursing home. These programs could help improve care for many of the 66,200 disabled Medicaid beneficiaries in Connecticut.[21]

Health Insurance Reform Improves Quality and Reforms the Delivery System.

- **Reduces preventable readmissions.** The current health care system does not place enough emphasis on improving quality of care. For example, nearly 20 percent of Medicare patients who are discharged from the hospital end up being readmitted within 30 days.[22] For Connecticut, that's 29,600 readmissions each year which could potentially be prevented with improved care coordination.[23] Health insurance reform will invest in innovations in primary care and will provide financial incentives to hospitals to better coordinate care at discharge to avoid preventable readmissions.

- **Lessens Paperwork.** Physicians spend on average about 140 hours and $68,000 a year just dealing with health insurance bureaucracy.[24] For the 15,257 physicians in Connecticut, this adds up to 2.1 million hours and $1 billion in costs.[25] By simplifying and standardizing paperwork and computerizing medical records, doctors will be able to focus on caring for their patients instead of dealing with bureaucracy.

- **Incentivizes primary care.** Roughly 5,600 doctors in Connecticut practice primary care and would qualify for a new 5 to 10 percent payment bonus under health insurance reform.[26]

- **Invests in the health primary care.** Approximately 313,000 people, or 9 percent of Connecticut's population, cannot access a primary care provider due to shortages in their communities.[27] Health insurance reform will expand and improve programs to increase the number of health care providers, including doctors, nurses, and dentists, especially in rural and other underserved areas.

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[1] Garrett B, Hoalan J, Doan L et al. *The Cost of Failure to Enact Health Reform: Implications for States.* September 2009.

[2] Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[3] Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

[4] Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

[5] Kaiser Family Foundation. 2009 Employer Health Benefits Survey.

[6] Kaiser State Health Facts. http://www.statehealthfacts.org/comparetable.jsp?ind=353&cat=7.

[7] Kaiser State Health Facts. http://www.statehealthfacts.org/comparetable.jsp?ind=353&cat=7.

[8] Rick Foster, Office of the Actuary, Centers for Medicare and Medicaid Services. Letter to Congressman Stark, June 25, 2009.

[9] Office of the Actuary. Centers for Medicare and Medicaid Services.

[10] Centers for Medicare and Medicaid Services.

[11] Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2008, Table II.A.2.

[12] Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2008.

[13] Hospital uncompensated care cost is estimated using a GAO model and the Hospital Cost Reports. Total uncompensated care is computed as hospital uncompensated care divided by 63% (Hadley and Holahan's study on "The Cost of Care for the Uninsured" for Kaiser in 2004 found that hospitals account for 63% of total uncompensated care). Data expressed in 2009 dollars using Centers for Medicare and Medicaid Services, "National Health Expenditure Data."

[14] Hospital uncompensated care cost is estimated using a GAO model and the Hospital Cost Reports. Total uncompensated care is computed as hospital uncompensated care divided by 63% (Hadley and Holahan's study on "The Cost of Care for the Uninsured" for Kaiser in 2004 found that hospitals account for 63% of total uncompensated care). Data expressed in 2009 dollars using Centers for Medicare and Medicaid Services, "National Health Expenditure Data."

[15] Garrett B, Hoalan J, Doan L et al. *The Cost of Failure to Enact Health Reform: Implications for States.* September 2009.

[16] U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2007 and 2008.

[17] Garrett B, Hoalan J, Doan L et al. *The Cost of Failure to Enact Health Reform: Implications for States.* September 2009.

[18] Kemper P, Komisar H, Alecxih L. Long-term care over an uncertain future: What can current retirees expect? Inquiry 2005; 42(4): 335-350.

[19] National Clearinghouse for Long-Term Care Information. http://www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Costs_Paying/index.aspx

[20] U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2008 and 2009.

[21] Based on CBOs estimated Federal Outlays. Allocated by state using disabled Medicaid enrollees by state from Kaiser Family Foundation statehealthfacts.org.

[22] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. NEJM 2009;360:1418-

28.
[23] Centers for Medicare and Medicaid Services.
[24] Casalino LP, Nicholson S, Gans DN, et al. What Does It Cost Physician Practices To Interact With Health Insurance Plans? *Health Affairs*, July/August 2009; 28(4): w533-w543.
[25] American Medical Association, Physicians Professional Data, year of data 2008, copyright 2008: Special Data Request.
[26] American Medical Association, Physicians Professional Data, year of data 2008, copyright 2008: Special Data Request.
[27] Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration (HRSA), Special Data Request, April 2009.

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Putting Americans In Control of Their Health Care

Key Provisions of Health Reform that Take Effect Immediately

1) Small Business Tax Credits

Offers tax credits to small businesses to make employee coverage more affordable. Tax credits of up to 35 percent of premiums will be available to firms that choose to offer coverage. *Effective beginning calendar year 2010.* (Beginning in 2014, the small business tax credits will cover 50 percent of premiums.)

2) No Discrimination Against Children with Pre-Existing Conditions

Prohibits new health plans in all markets plus grandfathered group health plans from denying coverage to children with pre-existing conditions. *Effective 6 months after enactment.* (Beginning in 2014, this prohibition would apply to all persons.)

3) Help for Uninsured American with Pre-Existing Conditions until Exchange is Available (Interim High-Risk Pool)

Provides access to affordable insurance for Americans who are uninsured because of a pre-existing condition through a temporary subsidized high-risk pool. *Effective in 2010.*

4) Ends Recissions

Bans insurance companies from dropping people from coverage when they get sick. *Effective 6 months after enactment.*

5) Begins to Close the Medicare Part D Donut Hole

Provides a $250 rebate to Medicare beneficiaries who hit the donut hole in 2010. *Effective for calendar year 2010.* (Beginning in 2011, institutes a 50 percent discount on prescription drugs in the donut hole; also completely closes the donut hole by 2020.)

6) Free Preventive Care under Medicare

Eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program. *Effective beginning January 1, 2011.*

7) Extends Coverage for Young People up to 26th Birthday through Parents' Insurance

Requires new health plans and certain grandfathered plans to allow young people up to their 26th birthday to remain on their parents' insurance policy, at the parents' choice. *Effective 6 months after enactment.*

8) Help for Early Retirees

Creates a temporary re-insurance program (until the Exchanges are available) to help offset the costs of expensive premiums for employers and retirees for health benefits for retirees age 55-64. *Effective in 2010.*

9) Bans Lifetime Limits on Coverage

Prohibits health insurance companies from placing lifetime caps on coverage. *Effective 6 months after enactment.*

10) Bans Restrictive Annual Limits on Coverage

Tightly restricts the use of annual limits to ensure access to needed care in all new plans and grandfathered group health plans. These tight restrictions will be defined by HHS. *Effective 6 months after enactment.* (Beginning in 2014, the use of any annual limits would be prohibited for all new plans and grandfathered group health plans.)

11) Free Preventive Care under New Private Plans

Requires new private plans to cover preventive services with no co-payments and with preventive services being

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exempt from deductibles. *Effective 6 months after enactment.*

12) New, Independent Appeals Process

Ensures consumers in new plans have access to an effective internal and external appeals process to appeal decisions by their health insurance plan. *Effective 6 months after enactment.*

13) Ensures Value for Premium Payments

Requires plans in the individual and small group market to spend 80 percent of premium dollars on medical services, and plans in the large group market to spend 85 percent. Insurers that do not meet these thresholds must provide rebates to policyholders. *Effective on January 1, 2011.*

14) Community Health Centers

Increases funding for Community Health Centers to allow for nearly a doubling of the number of patients seen by the centers over the next 5 years. *Effective beginning in fiscal year 2011.*

15) Increases the Number of Primary Care Practitioners

Provides new investments to increase the number of primary care practitioners, including doctors, nurses, nurse practitioners, and physician assistants. *Effective beginning in fiscal year 2011.*

16) Prohibits Discrimination Based on Salary

Prohibits new group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees. *Effective 6 months after enactment.*

17) Health Insurance Consumer Information

Provides aid to states in establishing offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals. *Effective beginning in fiscal year 2010.*

18) Holds Insurance Companies Accountable for Unreasonable Rate Hikes

Creates a grant program to support States in requiring health insurance companies to submit justification for all requested premium increases, and insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new Health Insurance Exchanges. *Starting in plan year 2011.*

Putting Americans In Control of Their Health Care

HEALTH REFORM DETAILS

What's New
- Improving Affordability and Accountability
- Cracking Down on Waste, Fraud and Abuse
- Ensuring Fiscal Sustainability
- Other Policy Improvements

Title I. Quality, Affordable Health Care for All Americans

Title II. The Role of Public Programs

Title III. Improving the Quality and Efficiency of Health Care

Title IV. Prevention of Chronic Disease and Improving Public Health

Title V. Health Care Workforce

Title VI. Transparency and Program Integrity

Title VII. Improving Access to Innovative Medical Therapies

Title VIII. Community Living Assistance Services and Supports Act (CLASS Act)

Title IX. Revenue Provisions

Title X. Reauthorization of the Indian Health Care Improvement Act

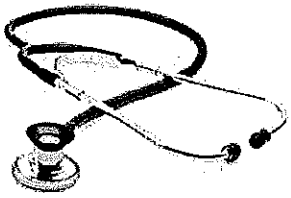
La Propuesta del Presidente

Health Reform puts American families and small business owners in control of their own health care.

Over the past year the House and the Senate have been working on an effort to provide health insurance reform that lowers costs, guarantees choices, and enhances quality health care for all Americans. Building on that year-long effort, the President's final legislation included the best ideas from both sides of the aisle offered in the course of the debate.

- Read the text of the Senate bill and the changes passed by the House.

What does health care reform mean for you?



Find Out Now

Health reform will make health care more affordable, make health insurers more accountable, expand health coverage to all Americans, and make the health system sustainable, stabilizing family budgets, the Federal budget, and the economy:

- It makes insurance more **affordable** by providing the largest middle class tax cut for health care in history, reducing premium costs for tens of millions of families and small business owners who are priced out of coverage today. This helps 32 million Americans afford health care who do not get it today – and makes coverage more affordable for many more. Under the plan, 95% of Americans will be insured.
- It sets up a **new competitive health insurance** market giving millions of Americans the same choices of insurance that members of Congress will have.
- It brings **greater accountability** to health care by laying out commonsense rules of the road to keep premiums down and prevent insurance industry abuses and denial of care.
- It will **end discrimination** against Americans with pre-existing conditions.
- It puts our **budget and economy on a more stable path** by reducing the deficit by more than $100 billion over the next ten years – and more than $1 trillion over the second decade – by cutting government overspending and reining in waste, fraud and abuse.

Key Provisions in Health Reform:

Health reform built off of the legislation that passed the Senate and improves on it by bridging key differences between the House and the Senate and includes several key Republican provisions.

One key improvement, for example, is eliminating the *Nebraska FMAP provision* and providing significant additional Federal financing to all States for the expansion of Medicaid. For America's seniors, the reform completely closes the Medicare prescription drug *"donut hole"* coverage gap. It strengthens the Senate bill's provisions that *make insurance affordable* for individuals and families, including protections for out-of-pocket costs, while also strengthening the provisions to *fight fraud, waste, and abuse in Medicare and Medicaid* to save taxpayer dollars. The threshold for the excise tax on the most expensive health plans will be raised from $23,000 for a family plan to $27,500 and will start in 2018 for all such plans.

- Read the Overview.
- Read About the Policies in Health Reform to Improve Affordability and Accountability.
- Read About the Policies in Health Reform to Crack Down on Waste, Fraud and Abuse.
- Read About the Policies in Health Reform to Contain Cost and Ensure Fiscal Sustainability.
- Read About the Other Proposed Policy Improvements in Health Reform.

Summaries of Key Elements of Health Reform:

- Title I: Quality, Affordable Health Care for All Americans
- Title II: The Role of Public Programs
- Title III: Improving the Quality and Efficiency of Health Care
- Title IV: Prevention of Chronic Disease and Improving Public Health
- Title V: Health Care Workforce
- Title VI: Transparency and Program Integrity
- Title VII: Improving Access to Innovative Medical Therapies
- Title VIII: Community Living Assistance Services and Supports Act (CLASS Act)
- Title IX: Revenue Provisions
- Title X: Reauthorization of the Indian Health Care Improvement Act

Putting Americans In Control of Their Health Care

Six Ways Health Reform will Help Small Businesses

Small businesses want to provide health coverage for their workers, but they face extraordinary challenges in doing so, including premiums that are 18 percent higher on average than large businesses pay for the same coverage. Health reform legislation signed by the President includes a number of important benefits to help make coverage more affordable:

Establishes a Small Business Health Care Tax Credit to Help Small Businesses Afford the Cost of Covering Their Workers.

- **Status Quo: Small Businesses Face High Costs in Providing Health Insurance to Their Employees** Small businesses face higher costs and few incentives to offer health insurance coverage to employees.
- **Solution: A New Tax Credit Takes Effect Immediately to Help Cover Premiums Small Businesses Pay.** The Small Business Health Care Tax Credit can cover up to 35 percent of the premiums a small business pays to cover its workers. In 2014, the rate will increase to 50 percent. Learn more about the Small Business Health Care Tax Credit.

Creates Health Insurance Exchanges to Increase Bargaining Power and Reduce Administrative Costs

- **Status Quo: Small Businesses Have Little Bargaining Power, Face High Administrative Costs.** Currently, small businesses face not only premiums that are 18 percent higher than large businesses pay, but also face higher administrative costs to set up and maintain a health plan. The premiums they pay have 3 to 4 times as much administrative cost built into them as plans in the large group market. They are also at a disadvantage in negotiating with insurance companies because they lack bargaining power.
- **Solution: Health Insurance Exchanges will Provide More Choice, Lower Prices, and Greater Bargaining Power for Firms with up to 100 Employees.** Health reform will change this dynamic. Starting by 2014, firms with 100 or fewer workers will be able pool their buying power and reduce administrative costs by purchasing insurance through an exchange. According to CBO, coverage that small businesses purchased through an exchange "would have lower administrative costs, on average, than the policies those firms would buy under current law, particularly for very small firms."

Ends Price Discrimination against Small Businesses with Sick Workers

- **Status Quo: Small Businesses with Sick Worker Face Higher Prices, Sudden Price Increases.** Currently, small businesses with just one sick worker can face significantly higher premiums, and having a worker fall ill can lead to a precipitous price increase -- raising premiums just when insurance is needed most.
- **Solution: Ending Price Discrimination Based on Illness.** Health reform will end this price discrimination. Starting in 2014, "community rating" rules will prohibit insurers from charging more to cover small businesses with sicker workers or raising rates when someone gets sick.

Increases Health Care Security to Unlock Entrepreneurship

- **Status Quo: Health Insurance Insecurity Creates "Job Lock," which Inhibits Entrepreneurship.** Our current health care system inhibits entrepreneurship and small business formation by locking workers -- especially those with families or with any sort of health problem --into jobs at large firms that offer family coverage and have a big enough risk pool to absorb the cost of covering pre-existing conditions. This "job lock" causes many workers to stay at large firms even if they would be more productive working at a small business or becoming an entrepreneur.
- **Solution: Health Security Empowers Entrepreneurship.** By providing health security for every American and eliminating exclusions for pre-existing conditions and price discrimination against those who are sick, health reform will make it easier for small businesses to attract the best workers and easier for entrepreneurs to strike out on their own.

Reduces the Hidden Tax on Small Business Employees with Health Insurance

- **Status Quo: Hidden Tax Adds $1,000 to Every Premium.** Currently, the cost of treating the uninsured adds a "hidden tax" of over $1,000 to every health care premium.
- **Solution: Reduce Hidden Tax by Dramatically Expanding Coverage.** Health reform will significantly reduce this tax by covering an additional 32 million additional Americans by 2019.

Reduces Premiums in the Small Group Market.

- **Status Quo: Higher Premiums Mean Coverage Is Unaffordable for Small Businesses.** In a recent national survey, nearly three-quarters of small businesses that did not offer benefits cited high premiums as the reason.
- **Solution: Health Reform Will Lower Costs, Making Coverage More Affordable.** Taken together, the measures described above will significantly reduce premiums for small businesses. According to CBO, health reform will reduce the cost of a given plan in the small group market by 1-4 percent by 2016.

SustiNet

Health care we can count on.

July 2009
SustiNet Board is formed

5 Committees & 3 Task Forces begin work

End of 2009
If nat'l health care reform enacted, **the SustiNet Board submits recommendations to the legislature within 60 days**

July 1, 2010
Task Forces and Committees report to General Assembly

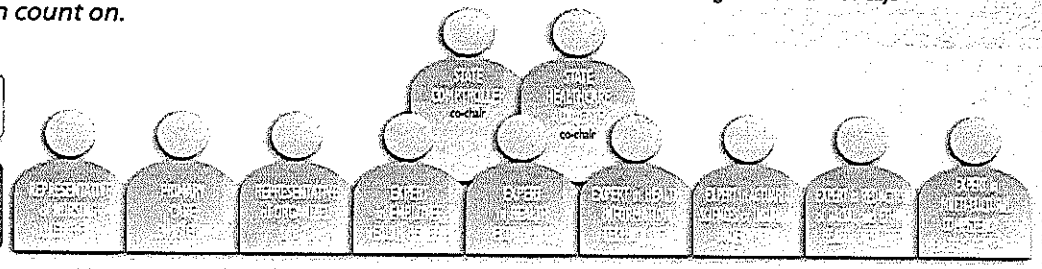
December 1, 2010
Office of Healthcare Advocate reports to SustiNet Board on model benefits packages

January 1, 2011
SustiNet Board submits draft legislation to the General Assembly

July 1, 2012
Enrollment begins in the SustiNet public health insurance plan

2009-2011

SustiNet Board works on implementation plan for SustiNet Connecticut's public health insurance choice.



Information Technology Committee
to make a plan for developing, acquiring, financing, leasing, or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers.

Medical Home Advisory Committee
composed of physicians, nurses, consumer representatives, and other qualified individuals chosen by the board. The committee must develop recommended internal procedures and proposed regulations for the administration of medical homes for SustiNet Plan members.

Health Care Quality Committee
to establish a health care provider committee to develop clinical care and safety guidelines for use by SustiNet providers. The committee must choose from existing nationally and internationally recognized care guidelines. It must continually assess the quality of evidence, the relevant costs, and the risks and benefits of treatments. The committee must have provider and consumer members.

Preventive Health Care Committee
to establish a preventive health care committee that uses evolving medical research to make recommendations to improve health outcomes for SustiNet Plan members in areas of nutrition, physical exercise, tobacco use, addictive substances, and sleep. The committee must have provider and consumer members.

Health Disparities & Equity Committee
to recommend how the SustiNet Plan shall reduce health disparities and inequities. The committee is composed of consumers, health care providers, leaders of community-based service organizations and philanthropic institutions, public health and academic experts and is racially, ethnically, gender and geographically diverse.

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

Tobacco Use Task Force The bill establishes a task force to study tobacco use by children and adults. It must examine evidence-based strategies for preventing and reducing tobacco use and developing a comprehensive plan to reduce tobacco use.

Health Care Workforce Task Force The bill establishes a task force to study the state's health care workforce. It must develop a comprehensive plan for preventing and remedying state-wide, regional, and local shortages of necessary medical personnel.

- *Committee work is informed by Task Forces*
- *All Committees and Task Forces forward their conclusions and recommendations to the SustiNet Board of Directors*
- *All Task Force work ends on January 1, 2011, when bill is introduced*
- *The SustiNet Board will identify public and private funding to support SustiNet mission and operations*
- *The SustiNet Board will make optimum use of opportunities created by new federal funding*

January 1, 2011

The SustiNet Health Partnership Board submits a bill to the legislature detailing the implementation of the SustiNet Plan and addressing how best to:

- Design the SustiNet Plan to improve health, quality of care, and access to care; and to slow the growth of health care spending
- Establish action plans for the effective management of chronic illness and implementation of preventive care, and the reduction of racial and ethnic disparities
- Assure adequate provider networks so that SustiNet Plan members have timely access to high quality care
- Set payment methods for health care providers that promote access to care and patient health and cover the cost of care
- Establish a range of benefit, premium and cost-sharing options for SustiNet Plan members
- Evaluate options for ensuring that both healthy and sick people will have access to affordable coverage
- Structure governance and administration for the oversight and implementation of the SustiNet Plan
- Secure private and public revenue sources, including how to maximize federal reimbursement

July 1, 2012

The following groups will able to join the SustiNet Plan:

- Small businesses employees
- Nonprofit employees
- Municipalities
- Retirees
- Dependents
- Those who are not offered employer sponsored insurance
- HUSKY Plan Parts A & B
- Medicaid
- SAGA

The SustiNet Board will also develop recommendations to ensure that employers can choose to participate in the SustiNet Plan, as well as individuals who have unaffordable or inadequate employer sponsored insurance.

Landmark universal health care reform that controls costs, promotes good health and delivers a quality, affordable health care choice to Connecticut residents.