
OLR Bill Analysis**sHB 6305*****AN ACT CONCERNING IMPLEMENTATION OF THE SUSTINET PLAN.*****SUMMARY:**

This bill implements the recommendations of the SustiNet Health Partnership board of directors established by PA 09-148. It establishes the details of, and processes for, implementing the “SustiNet Plan,” a health insurance program consisting of multiple, coordinated health insurance plans providing or offering, over a phased-in period, health insurance products to state employees; enrollees in Medicaid, HUSKY Plan Part A and Part B, or HUSKY Plus; municipal, municipal-related, nonprofit, small, and other employers; and individuals in the state.

The bill establishes the SustiNet Plan Authority as a quasi-public authority to carry out the SustiNet Plan. The authority has a 15-member board of directors including the comptroller, Department of Social Services (DSS) commissioner, and others appointed by the governor and legislative leaders. The authority is charged with promoting access to high-quality, patient-centered health care and can implement cost-controlling mechanisms to improve the quality, efficiency, and effectiveness of health care services provided. The bill directs the authority to encourage the use of patient-centered care through primary care case management and patient-centered medical homes.

Beginning January 1, 2012, the state employee health plan, Medicaid, HUSKY Part A and Part B, HUSKY Plus, Charter Oak, and a new basic health program become known as SustiNet Plans and are given new designations accordingly (SustiNet “A” through “E”). The bill requires the DSS commissioner, beginning January 1, 2014, to implement the “basic health program” option provided for in the federal health care reform law (the Patient Protection and Affordable

Care Act,” referred to as the “ACA”). Adults with incomes between 134% and 200% of the federal poverty level (FPL) who are ineligible for Medicaid are eligible for this program, which would be eligible for federal funding.

Beginning July 1, 2011, the comptroller must offer coverage under the state employee plan to nonstate public employees and their retirees if the comptroller receives and approves an application from such an employer. A “nonstate public employer” is a municipality, or other political subdivision of the state, including a board of education, quasi-public agency, or public library.

The bill creates a new plan option, Sustinet “G,” which is part of the Sustinet Plan but separate from Sustinet coverage groups A to E. (This has been referred to as the “public option.”) At the earliest feasible time on or after January 1, 2012, the authority must offer coverage under Sustinet G to employees and retirees of certain employer categories. Beginning January 1, 2014, it must offer Sustinet G coverage to all individuals and employers in Connecticut if the authority determines that this coverage is financially viable and does not require General Fund appropriations. Ongoing expenses of Sustinet G must be funded by premium payments.

The bill also addresses Sustinet Plan benefits and cost sharing, establishes certain accounts, requires audits and reporting, addresses the sharing and confidentiality of information, makes a number of conforming and technical changes, and repeals existing statutory provisions on the development of the Sustinet plan.

EFFECTIVE DATE: Upon passage

§ 3—SUSTINET PLAN AUTHORITY

Board of Directors

The bill establishes the Sustinet Plan Authority as a quasi-public authority to carry out the Sustinet Plan, with authority powers vested in a 15-member board of directors. Members are the comptroller, Department of Social Services (DSS) commissioner (both ex-officio,

voting members), and

1. three board members appointed by governor, one who is a primary care physician in active practice, one knowledgeable and experienced in measuring health care quality, and one with expertise in health care administration;
2. two members appointed by the Senate president pro tempore, one a representative of hospitals and one a Sustinet plan member;
3. two appointed by the House speaker, one a small employer and one a Sustinet plan member;
4. one who represents organized labor, appointed by the Senate majority leader;
5. one who represents a nonprofit health care center, appointed by the House majority leader;
6. one who is an oral health care provider, appointed by the Senate minority leader; and
7. one who is a mental health advocate, appointed by the House minority leader.

These 13 members then appoint two additional directors to the board by a majority vote. Anyone previously appointed to the Sustinet Health Partnership board of directors is eligible for appointment to the authority board.

Appointed directors cannot delegate representatives to perform their duties under the bill.

Board members are not compensated but are reimbursed for their expenses in performing their official duties.

Board Chairpersons

The board has two chairpersons, one of whom must be appointed

by the governor, and one appointed jointly by the Senate president pro tempore and the House speaker. Both must be approved by the House and Senate. The board must annually elect two members to serve as vice chairpersons.

Board Members' Terms

After the initial appointments, the members serve staggered, four-year terms. Beginning September 1, 2011, the governor's three appointees and the two directors initially appointed by a vote of the board serve a four-year term. The four directors initially appointed by the House speaker and the Senate president pro tempore serve a three-year term. The four directors initially appointed by the House and Senate majority and minority leaders serve a two-year term. Afterwards, all members are appointed for a four-year term beginning on September first of the appointment year. Each director serves at the pleasure of his or her appointing authority but no longer than the appointing authority's term of office or until the director's successor is appointed and qualified, whichever is longer. But no director can serve longer than three months after the term of his or her appointing authority.

Before starting his or her duties, each director must take the constitutional oath.

Any appointed director who fails to attend three consecutive board meetings or 50% of all meetings held in any calendar year is deemed to have resigned. Any appointed director may be removed by his or her appointing authority for misfeasance, malfeasance, or willful neglect of duty as determined by the appointing authority. The appointing authority must fill any vacancy for the unexpired term and that new director may be reappointed for full and subsequent terms. If an appointing authority fails to make an initial board appointment or an appointment to fill a board vacancy within 90 days of the vacancy date, the appointed directors, by majority vote, must make the appointment.

Executive Director of the Authority

The board chairpersons, in consultation with the board, must appoint an authority executive director. The executive director cannot be a member of the board and serves at its pleasure with the board determining compensation. The executive director supervises the authority's administrative affairs and technical activities according to board directives. He or she is exempt from the classified service.

The bill (§ 18) adds the executive director to the Health Information Technology Exchange of Connecticut board of directors, created under PA 10-117.

Quorum; Transacting Business

Board meetings are held at times specified in the board's bylaws and at other times as chairpersons deem necessary. Nine members constitute a quorum for transacting any business or exercising any authority power. A majority of directors present at any meeting where there is a quorum can act. A vacancy in board membership does not affect the directors' right to exercise all the board's rights and perform its duties. Approved board resolutions take effect immediately and need not be published or posted.

The board can delegate to three or more directors any powers and duties it deems necessary and proper. It must establish such committees, subcommittees, or other entities it deems necessary to further its purposes, including a finance committee.

The bill provides that it is not a conflict of interest for a director, officer or employee of an institution or business entity, including a health care institution, or for anyone having a financial interest in such an institution (but the bill does not mention "business entity" in regard to financial interest) to serve as a board member; but such a director, officer, employee or person must abstain from deliberation, action and vote by the board under sections 4, 7, 11, 16, 17 and 19 of this bill (see below) with respect to the institution or business entity of which he or she is a director, officer or employee or in which he or she has a financial interest.

Each board member must provide a \$50,000 surety bond or instead, the chairpersons of the board can execute a blanket position bond covering each member, the executive director, and other authority employees. Each surety bond must be (1) conditioned on faithful performance, (2) executed by a surety company authorized to transact business in this state as surety, and (3) approved by the attorney general and filed in the office of the secretary of the state. The authority pays the cost of each bond.

The board must adopt written procedures for:

1. adopting an annual budget and plan of operations, including a requirement for board approval before the budget or plan can take effect;
2. hiring, dismissing, promoting, and compensating employees, including an affirmative action policy and a requirement for board or executive director approval before a position may be created or a vacancy filled;
3. acquiring real and personal property and personal services, including a requirement for board approval for any nonbudgeted expenditure over \$5,000;
4. contracting for financial, legal, and other professional services, including a requirement that the authority solicit proposals at least once every three years for each such service it uses; and
5. the use of surplus funds to the extent authorized under any statute.

Authority Duration and Termination

The authority continues as long as it has statutory authority to exist and until it is terminated by law. Upon its termination, all its rights and properties pass to and are vested in the state.

Quasi-Public Agency Law

The bill applies all state laws on quasi-public agencies to any officer,

director, designee, or employee appointed as a member, director, or officer of the authority.

Freedom of Information

The authority is generally subject to the Freedom of Information Act, except for the following items which are not subject to disclosure:

1. the names and applications of Sustinet Plan enrollees;
2. health information of any Sustinet Plan applicant or enrollee;
3. information relating to provider negotiations and provider compensation arrangements, provided information relating to Medicaid, HUSKY Plan Part A and Part B, HUSKY Plus, and the Charter Oak Health Plan is subject to disclosure; and
4. information exchanged between the authority and DSS, the Department of Public Health (DPH), the Insurance Department (DOI), the comptroller, and any other relevant state agency pursuant to confidentiality agreements entered into according to the bill's provisions (see § 10 below).

§ 4—SUSTINET PLAN CONSUMER ADVISORY BOARD

The bill establishes the Sustinet Plan Consumer Advisory Board consisting of seven plan consumers, representing the different populations served by the Sustinet Plan. Initially, the advisory board consists of two chairpersons, appointed by the authority's chairpersons, who each serve a one-year term, but may be reappointed as chairpersons when that term expires. The advisory board chairpersons must, within 30 days after being appointed, establish procedures for appointing an additional five consumers to the advisory board. These members serve staggered terms and afterwards are appointed by the advisory board chairpersons. After the initial appointment of the advisory board, consumers who want to serve as advisory board members must be selected by a majority vote of the existing board members. The advisory board must develop, approve, and implement a board member selection process. No more than two members can be professional consumer advocates who presumably

must also be Sustinet plan consumers.

The advisory board is responsible for issuing consumer impact statements that describe the general effects on consumers of major actions, as the board determines, taken by the Sustinet Plan Authority board. The advisory board must prepare these statements to accompany publication of authority board decisions. The advisory board must advise authority board of directors on issues relating to Sustinet Plan consumers. The authority may make staff available to assist advisory board meetings.

§ 5—POWERS AND DUTIES OF THE SUSTINET PLAN AUTHORITY

The bill specifies that the purpose of the Sustinet Plan Authority is to promote access to high-quality health care that is effective, efficient, safe, timely, patient-centered, and equitable. The bill gives the authority a variety of powers and duties, including to:

1. sue and be sued in its own name, and plead and be impleaded;
2. employ assistants, agents, and other employees as needed, and use consultants, actuaries, attorneys, and appraisers as necessary to carry out its purposes;
3. make and enter into all contracts and agreements necessary, incidental, or consistent with the purposes the bill and the law governing disclosure of information concerning DSS program applicants and participants (CGS § 17b-90), and including contracting with insurers or other entities for administrative purposes such as claims processing, credentialing of providers, utilization management, care management, disease management, and customer service;
4. solicit bids from individual providers and provider organizations and arrange with insurers and others for access to existing or new provider networks and take other steps to provide Sustinet Plan members with access to timely, high-quality, health care throughout the state and, when appropriate,

- health care outside the state's borders;
5. enter agreements with any state agency to carry out the bill's purposes;
 6. accept from the state financial assistance, revenues, or the right to receive revenues with respect to any program under the authority's supervision;
 7. solicit, receive, and accept money, property, labor, or other things of value from any source, including gifts or grants from any philanthropic organization, department, agency or instrumentality of the United States or Connecticut;
 8. acquire, lease, purchase, own, manage, hold, and dispose of real property, and lease, convey, or deal in or enter into agreements made with respect to such property on any terms necessary, provided all acquisitions of real property for the authority's own use made with state appropriations or with state bond proceeds are subject to the approval of the Office of Policy and Management (OPM) secretary and the state facility plan (CGS § 4b-23);
 9. obtain insurance against any liability or loss concerning its property and other assets;
 10. purchase reinsurance or stop-loss coverage, set aside reserves, or to take other prudent steps to avoid excess exposure to risk in the authority's administration of health insurance plans;
 11. account for and audit its funds and those of any entity it funds;
 12. establish SustiNet health care plans in accordance with the bill and the state medical assistance program statutes (CGS § 17b-261);
 13. survey consumers, employers, and providers on health care and health care coverage issues; and

14. do everything necessary or convenient to carry out the authority's purposes.

In addition to these powers, the authority must:

1. set payment methods for licensed health care providers that (a) reflect evolving research and experience both within and outside the state, (b) promote access to health care and patient health, (c) prevent unnecessary health care spending, and (d) to the extent feasible and consistent with delivery system and payment reforms, ensure fair compensation to cover the reasonable cost of furnishing necessary care;
2. promote joint contracting efforts on behalf of state agencies wherever possible to achieve administrative savings, including facilitating joint negotiation of any administrative service organization (ASO) contract to provide services to state employees, Medicaid, HUSKY Plan Part A and Part B, HUSKY Plus, and Charter Oak Health Plan enrollees, as long as any joint ASO contract is not effective until the State Employee's Bargaining Agent Coalition (SEBAC) provides written consent to the comptroller that it will incorporate the terms of any change into its collective bargaining agreement;
3. ensure that any agreement or contract entered into with an ASO to serve any Sustinet Plan population does not contain payment mechanisms that provide an inherent incentive to deny care;
4. negotiate on behalf of participating Sustinet Plan providers to obtain discounted prices for vaccines and other health care goods and services;
5. establish and maintain a web site for timely posting of all authority public notices and other information it deems relevant in educating the public about the Sustinet Plan; and
6. maximize federal funding opportunities, including increased reimbursement revenue.

§ 6—DESIGNATION OF VARIOUS SUSTINET PLANS

Beginning January 1, 2012, the state employee plan, Medicaid, HUSKY Part A and B, HUSKY Plus, Charter Oak, and the basic health program (see §§ 7-8 below) are all to be known as “SustiNet Plans.” The bill designates these as follows:

1. HUSKY Plan, Part A becomes “SustiNet A”;
2. HUSKY Plan, Part B and HUSKY Plus is “SustiNet B”;
3. Charter Oak Health Plan is “SustiNet C”;
4. Medicaid is “SustiNet D”;
5. state employee health care coverage is “SustiNet E”; and
6. a new plan option (the public option) is “SustiNet G.”

Plan members must be given identification cards with an identical design. Plan membership categories can be identified by discreet designations on the card as prescribed by the authority.

State Employee Health Plan

Beginning January 1, 2012, the comptroller must administer the state employee plan according to rules established by the SustiNet Plan Authority and terms to which SEBAC consents in writing. The authority may establish rules concerning benefits, cost-sharing, utilization management, care coordination, disease management, evidence-based best practices, health care delivery systems, health care pilot programs, provider payment methods, provider network management, provider credentialing, and customer service.

On and after January 1, 2012, the comptroller must continue to obtain health insurance in accordance with (1) existing law for state employees and state retirees (CGS § 5-259) and (2) direction from the authority. The comptroller may jointly negotiate agreements with other agencies for services in accordance with the bill (see sections 10 and 11 below). The comptroller must continue to make payroll deductions for state employees and to enroll and disenroll employees

and retirees, and may administer customer relations for such employees and retirees. The Health Care Cost Containment Committee (HCCCC) must continue to advise the comptroller on issues relating to state employee health care. (The HCCCC is the committee established by the ratified agreement between the state and SEBAC.)

No change in the terms of the state employee plan is effective until SEBAC provides written consent to the comptroller that it agrees to incorporate the terms of the change into its collective bargaining agreement.

Department of Social Services Programs

DSS remains the single state agency for administering the Medicaid program, the HUSKY Plan Part A and Part B, and HUSKY Plus programs, and the Charter Oak Health Plan. The bill specifies that, beginning January 1, 2012, DSS may immediately implement recommendations from the Sustinet Plan Authority concerning the administration of these programs, including rules concerning utilization management, health care coordination, disease management, evidence-based best practices, health care delivery systems, provider payment methods, provider network management, provider credentialing, pilot programs, and customer services. At the earliest feasible date, DSS must contract with the Sustinet Plan Authority to provide or manage the provision of all covered health care services to beneficiaries of these programs.

The department must immediately seek any federal approval necessary to implement this arrangement, including delivery system and payment reforms recommended or implemented by the Sustinet Plan Authority. The plan authority cannot establish or amend requirements relating to covered programs; programs with respect to enrollment, eligibility, cost-sharing, administrative appeal rights; and provider auditing. DSS continues to administer requirements concerning these matters according to applicable statutory requirements. Beginning January 1, 2012, the DSS commissioner may jointly negotiate agreements with other state agencies for services in accordance with the bill (see sections 10 and 11 below).

§§ 7-8—MEDICAID AND OTHER PUBLIC HEALTH COVERAGE CHANGES***Changes in Medicaid Income Limits***

The bill provides that, beginning January 1, 2014, Medicaid must be provided to all adults, including childless adults and needy caretaker relatives who qualify for HUSKY A adult coverage under federal law (Section 1931 of the Social Security Act), with family income up to 133% of the federal poverty level (FPL), regardless of assets. Currently, 133% of the FPL for one person is \$14,483 annually.

Under current law, children and their caretaker adult relatives can receive HUSKY A (Medicaid) under Section 1931 if their income is up to 185% of the FPL (currently \$20,146 annually for one person). Childless adults are eligible under an ACA provision for Medicaid if their income is about 60% of the FPL (Section 1902 (a)(10)(A)(i)(VIII) of the Social Security Act). No asset test is applied to either group. Under the bill, starting January 1, 2014, children are still covered up to 185% of the FPL. But their parents and caretaker relatives and childless adults are covered up to 133% of the FPL.

Under the bill, children and their caretaker relatives up to 185% of FPL are eligible for Medicaid once the bill passes if they fall into the ACA provision for childless adults. Since these individuals are already covered by Section 1931, it is unclear what, if any, effect this provision has. The federal Affordable Care Act (ACA; the federal health care reform law, P.L. 111-148) requires states to offer Medicaid coverage to adults with incomes up to 133% of the FPL starting January 1, 2014 and provides significant federal reimbursement for this expansion.

New Basic Health Program for Adults under Age 65

The bill requires the DSS commissioner, beginning January 1, 2014, to implement the “basic health program” option provided for in the ACA. Adults with incomes between 134% and 200% of the FPL who are ineligible for Medicaid are eligible for this program. The bill explicitly includes in the program parents of HUSKY A children (but not caretaker relatives) with incomes above 133% of FPL and certain legal immigrants. The program must include the same benefits, cost-

sharing limits, and other consumer safeguards that apply to Medicaid beneficiaries.

The bill provides that, to the extent that federal funds the state receives for the basic health program exceed its costs, the excess must be used to increase reimbursement rates for medical providers serving individuals enrolled in Medicaid or the new basic health program.

It requires the DSS commissioner to take any necessary actions to maximize federal funds available for establishing the basic health program.

The bill establishes a “Basic Health Program Account” as a separate, nonlapsing General Fund account, to hold any money required by law to be deposited in it. The bill authorizes the Sustinet Plan Authority to spend money in the account to operate the basic health program, in conformance with federal law. (HB 6587, favorably reported by the Human Services Committee to the Appropriations Committee on March 22, requires DSS to establish a Basic Health Program starting January 1, 2014.)

§§ 9-10—SHARING INFORMATION

The bill requires DSS to disclose to an authorized representative of the authority information about program participants or applicants necessary to carry out the authority’s purposes.

It allows the authority to enter into confidentiality agreements with the Department of Public Health (DPH), DSS, the Department of Insurance (DOI), the comptroller and other relevant state agencies that conform with the federal Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal laws, to obtain necessary information concerning Sustinet plan members. This information is not subject to disclosure under the Freedom of Information Act.

§§ 11, 20—SUSTINET PLAN OBJECTIVES, GOALS, AND ELEMENTS

The bill requires the Sustinet Plan to be administered to slow the

growth of health care costs and improve the quality of services and members' health outcomes. It authorizes the authority, consistent with applicable collective bargaining agreements and federal law, to implement, modify, and supplement the health care delivery system and payment reforms based on evolving evidence. The authority can work with other public and private entities to implement multi-payor initiatives that promote promising delivery systems and payment reforms. In doing so, the authority can work with any established "convenor authority." (The bill does not define "convenor authority.")

The bill authorizes the comptroller to serve as a convenor authority for health care institutions, facilities, and providers in the state. He or she must comply with all applicable federal law in exercising this authority. The comptroller must implement policies and procedures necessary to do this while in the process of adopting regulations. He or she must print notice of in the intent to adopt regulations in the *Connecticut Law Journal* within 20 days after the date he or she implements these policies and procedures, which are valid until final regulations are adopted.

Patient-Centered Medical Care

The bill directs the authority to strongly encourage the use of patient-centered medical care by implementing primary care case management (PCCM) and patient-centered medical homes (PCMH) for Sustinet Plan members. The authority can make or facilitate grants and loans that (1) help providers transition to patient-centered care systems, (2) provide technical assistance and training for community teams certified or sponsored by the authority, and (3) establish regional pilot programs.

A PCMH, as defined in the ACA, is a mode of care that includes personal physicians or other primary care providers, whole-person orientation, coordinated and integrated care, safe and high quality care through evidence-informed medicine, appropriate use of health information technology, continuous quality improvements, expanded access to care, and payment that recognizes added value from additional components of patient-centered care.

A provider serving as a PCMH must provide services that include:

1. (a) advising plan members with chronic conditions on methods to monitor and manage their own conditions, (b) working with plan members to set goals on exercise, nutrition, tobacco use, sleep and other behaviors, (c) implementing best practices on following medical instructions, and (d) providing translation services and culturally competent communication strategies;
2. providing care coordination including (a) managing transitions between home and hospital, (b) proactive monitoring to ensure a member receives all recommended primary and preventive services, (c) basic mental health services, including referrals, (d) stress management, including appropriate referrals to employee assistance programs, (e) referrals to nonmedical services such as housing and nutrition programs, domestic violence resources, and other support groups, and (f) when a plan member has complex health conditions and gets care from multiple providers, sharing information and creating a single, integrated treatment plan; and
3. providing accessible, 24-hour consultative services by phone, email, and quickly scheduled appointments.

Provider Payments

The authority must establish provider payment methods that encourage payment for quality care and greater access. These include multi-payer and value-based purchasing pilot programs, bundled and global payments, increasing and decreasing Medicaid reimbursement for specific services or innovations, and alternatives to fee-for-service payments. To the extent warranted by available evidence, the authority, by July 1, 2012, must establish goals for increasing the percentage of Sustinet expenditures made under alternative payment methods. It must also develop ways to measure the success of each method.

Other Goals and Objectives

The authority must also:

1. provide community-based preventive care services at job sites, schools, and other community locations;
2. develop care standards including requirements for coordination with medical homes and primary care case managers;
3. make the Sustinet plan subject to all state health insurance mandates;
4. develop recommendations for public education and outreach, targeting populations that are underserved by the health care system;
5. work with other state organizations to minimize the health information technology (HIT) cost to providers, including taking advantage of available federal resources, leveraging the combined purchasing power of the state's providers, and ensuring the privacy and security of Sustinet Plan member data;
6. periodically review the authority's coverage of preventive care based on the most current and reliable evidence;
7. implement multi-year plans to achieve measurable objectives in prevention and management of chronic illness, reducing racial and ethnic disparities in health care and outcomes, and reducing the number of uninsured people;
8. within available appropriations, develop and implement policies and procedures to identify, qualify for subsidies, enroll, and retain in coverage those otherwise uninsured, which may be developed in collaboration with state, federal, and local agencies and the state's insurance exchange (see BACKGROUND), as well as individual providers and institutions;
9. create a pay-for-performance system to reward health care

providers for improvements in health care quality and safety, and reductions in disparities;

10. establish procedures on the use of preferred drug lists and formularies;
11. establish procedures to prevent adverse selection;
12. negotiate discounts on vaccines and other goods and services for Sustinet providers; and
13. comply with state health insurance disclosure laws.

Sustinet “G”

The bill requires the authority to offer a multitude of Sustinet “G” plans with a variety of benefits, out-of-pocket costs, and provider network arrangements. Each plan must provide comprehensive, commercial-style benefits including dental, vision, and physical and mental health parity coverage. Plans must, to the extent feasible, include patient-centered medical homes, emphasize prevention, and integrate physical and behavioral health care. (More on Sustinet G follows below in §§ 6 and 15.)

Standing Committees

The bill requires the authority board to establish standing committees to:

1. provide advice and planning on HIT, including encouraging all Sustinet providers to use electronic health records;
2. address methods and metrics to prevent and control chronic illnesses and significant health risks, including diabetes, hypertension, asthma, tobacco use, and obesity;
3. develop recommendations to simplify provider paperwork and procedures, including provider enrollment, claims filing, and utilization review; and
4. advise the board on attracting primary care physicians,

specialists, and nurses to Sustinet.

The board must also implement policies and procedures to encourage use of evidence-based medicine. These include establishing a committee of clinicians to review and recommend for board adoption clinical care guidelines for disease treatment that are developed by national or international authorities. Any system the board adopts that rewards providers for meeting such guidelines must have mechanisms for a provider to document reasons for not using the guidelines that include reasons related to an individual patient's condition.

SUSTINET ACCOUNT (§ 12)

The bill establishes the "Sustinet Account" as a separate, nonlapsing General Fund account. All Sustinet Plan premiums received under the nonstate public employer and Sustinet G provisions and all public and private funds provided to the authority must go into the account. The comptroller may make expenditures from the account at the direction of the Sustinet Plan Authority executive director.

By January 1, 2012, the executive director must hire a consultant to determine existing state expenditures on health care funding for each category of Sustinet Plan coverage. The director must determine an appropriate projection for normal health care cost increases for each coverage group. If, after two years of Sustinet operations, the director can satisfactorily demonstrate to the OPM secretary that Sustinet has reduced overall per capita spending on enrolled coverage groups, then the amount of agreed-to savings must be placed in the account. The authority may use the funds to make grants to providers, increase provider rates, or to improve the Sustinet Plan.

§§ 6, 13—COVERAGE FOR NONSTATE PUBLIC EMPLOYERS UNDER THE STATE EMPLOYEE PLAN

Beginning July 1, 2011, the comptroller must offer coverage under the state employee plan to nonstate public employees and their retirees if the comptroller receives an application and application from a nonstate public employer (see below). The bill defines a "nonstate

public employer” as a municipality or other political subdivision of the state, including a board of education, quasi-public agency, or public library. The comptroller may not offer such coverage until SEBAC has given its written consent to the comptroller that it agrees to incorporate the terms of the coverage into its collective bargaining agreement.

Under the bill, initial open enrollment for nonstate public employers must be for coverage that begins January 1, 2012. Coverage offered in subsequent enrollment periods must begin July 1 or another date as determined by the comptroller.

Coverage Term, Renewal, and Withdrawal

An employer group that wants to participate in the state employee plan group must agree to benefit periods of at least two years. The comptroller may modify this, if necessary, due to implementation of the ACA. An employer may apply for renewal before the end of each benefit period.

The bill requires the comptroller to develop procedures for an employer group to (1) apply for initial plan participation and subsequent renewal and (2) withdraw from plan participation. The procedures must include terms and conditions under which a group can withdraw before the benefit period ends and how to obtain a refund for any unearned premiums paid. The procedures must provide that withdrawal by nonstate public employees covered under a collective bargaining agreement be in accordance with any applicable state collective bargaining laws for municipal employees and teachers.

Application Form

The bill requires the comptroller to create an application for employer groups seeking coverage under the state plan. In the application, the employer must disclose whether it will offer any other plan to the employees offered the state plan.

Status as a Governmental Health Plan Under Federal ERISA

The federal Employee Retirement Income Security Act (ERISA) sets certain fiduciary and disclosure standards for private-sector health

plans and exempts governmental plans from these requirements.

The bill authorizes the comptroller to deny an employer admission to the state health plan if the comptroller determines that granting such coverage will affect the state plan's status as a governmental plan. In addition, the comptroller must stop accepting applications from nonstate public employers.

The comptroller must resume accepting applications from these employers if he or she subsequently determines that granting them coverage will not affect the plan's ERISA status. The comptroller must publicly announce any decision to stop or resume accepting applications.

Taft-Hartley Exception

The bill prohibits an employee from enrolling in the state plan if his or her employer covers the employee under a health insurance plan or arrangement issued to, or in accordance with, a trust established through collective bargaining under the federal Labor Management Relations (i. e., "Taft-Hartley") Act.

Permissive and Mandatory Collective Bargaining for Nonstate Public Employers

The bill makes a nonstate public employer group's initial participation in the state employee plan a permissive subject of collective bargaining. If the union and the employer agree in writing to bargain over the initial participation, then the decision to join the plan is subject to binding arbitration. The bill makes a nonstate public employer group's continuation in the state plan a mandatory subject of collective bargaining, subject to binding interest arbitration. .

The bill specifies that a board of education and a municipality are considered separate employers and must apply separately for coverage under the state plan.

Application and Decision Process for All Eligible Employers

The bill establishes two different processes for determining whether a nonstate public employer's application for coverage will be accepted,

depending on whether the (1) application covers all or some employees or (2) the employer will offer other health plans.

If the application covers all of an employer's employees, the bill requires the comptroller to accept the application for the next open enrollment period and give the employer written notice of when coverage begins. But if the application covers only some of an employer's employees or it indicates the employer will offer other health plans and the state health plan, the comptroller must forward the application to a health care actuary within five days of receiving it.

Within 60 days of receiving an application from the comptroller, the actuary must determine whether it will shift a significantly disproportionate part of the employer group's medical risks to the state plan. If it does, the actuary must certify this in writing to the comptroller and include the specific reasons for the finding and the information used in making it.

The bill requires the comptroller to consult with a health care actuary that will develop actuarial standards for assessing the shift in medical risks of an employer's employees to the state plan. The comptroller must present the standards to the HCCCC for its review and evaluation before the standards are used.

Under the bill, if the actuary certifies a disproportionate risk shift, the comptroller must deny the application and give the employer and HCCC written notice that includes specific reasons for denial. If the comptroller does not receive a certification, he must accept the application and give the employer written notice of when coverage begins.

Exceptions to Actuarial Review

The bill prohibits the comptroller from forwarding to the actuary an application to cover fewer than all of its employees because (1) the employer decides not to cover temporary, part-time, or durational employees or (2) individual employees decline coverage. Presumably, therefore, the comptroller must accept the application for the next

open enrollment period and notify the employer of when coverage begins.

Regulations Regarding Actuarial Review

The bill authorizes the comptroller to adopt regulations to establish procedures for the HCCCC's reviews of actuarial standards.

Self-Insured Plan is Not Unauthorized Insurer or "MEWA"

The bill specifies that the state employee plan is not an unauthorized insurer or a "multiple employer welfare arrangement" (MEWA).

Retirees

Nonstate employer groups eligible to cover employees under the state plan also may seek coverage for their retirees. The bill states that it does not diminish any right to retiree health insurance under a collective bargaining agreement or state law.

The bill requires the employer to remit premiums for retirees' coverage to the comptroller in accordance with the bill's provisions. It specifies that a retiree's premiums for coverage under the state plan must be the same as those the state pays, including premiums retired state employees pay, if applicable.

The application process and decision notice requirements with respect to covering an employer's retirees, including actuarial review if the employer proposes to cover fewer than all retirees, is the same as for current employees (described above). But the bill prohibits the comptroller from forwarding an application to the actuary when the only retirees an employer excludes from the proposed coverage are those who (1) decline coverage or (2) are Medicare enrollees.

Premiums

The bill requires the premiums an employer pays to participate in the state plan to be the same as those the state pays, including any premiums state employees and retirees pay. An employer must pay premiums monthly to the comptroller in an amount the comptroller

determines.

Administrative Fee, Fluctuating Reserves Fee, and Employee Contribution

The bill authorizes the comptroller to charge nonstate public employers an administrative fee calculated on a per-member, per-month basis. In addition, the comptroller can charge a fluctuating reserves fee that the comptroller deems necessary to ensure an adequate claims reserve. It permits an employer to require a covered employee to pay part of the coverage cost, subject to any applicable collective bargaining agreement.

Penalties for Late Payment of Premiums

If a nonstate public employer does not pay its premiums by the 10th day after the due date, the bill requires it also to pay interest, retroactive to the due date, at the prevailing rate, as the appropriate entity determines.

If a nonstate public employer fails to make premium payments, the bill authorizes the comptroller to direct the state treasurer, or any state officer who is the custodian of state money (i. e., grant, allocation, or appropriation) owed the employer, to withhold payment. The money must be withheld until (1) the employer pays the comptroller the past due premiums or interest or (2) the treasurer or state officer determines that arrangements, satisfactory to the treasurer, have been made for payment. But the the treasurer or state officer cannot withhold state money if doing so impedes receiving any federal grant or aid.

If a nonstate public employer is either not owed state money or has not had money withheld, the bill allows the comptroller to terminate the group's participation in the state plan for failure to pay premiums (but apparently not interest) if he gives the employer at least 10 days notice. The employer can avoid termination by paying premiums and interest due in full before the termination's effective date.

The bill allows the comptroller to ask the attorney general to bring an action in Hartford Superior Court to recover any premiums and

interest owed or seek equitable relief from a terminated employer.

§ 14—NONSTATE PUBLIC HEALTH CARE ADVISORY COMMITTEE

The bill establishes a 12-member Nonstate Public Health Care Advisory Committee, which must make recommendations to the HCCCC regarding health care coverage for nonstate public employees.

The committee must consist of nonstate public employers and employees participating in the state plan. Specifically, members must include three representatives each of (1) municipal employers, (2) municipal employees, (3) board of education employers, and (4) board of education employees. Of the three representatives in each category, one must represent a town with (1) 100,000 or more people, (2) at least 20,000 but under 100,000 people, and (3) under 20,000 people. The comptroller appoints the committee members. (The bill does not indicate who serves as committee chairperson or how the person is selected.)

SUSTINET “G” COVERAGE FOR NONSTATE PUBLIC EMPLOYEES, MUNICIPAL-RELATED EMPLOYERS, NONPROFIT EMPLOYERS, AND OTHER EMPLOYERS (§§ 6, 15)

At the earliest feasible date on and after January 1, 2012, the authority must offer coverage under SustiNet G to employees and retirees of the following employer categories who request such coverage and whose application is approved according to the bill’s provisions: (1) nonstate public employers, (2) municipal-related employers, (3) small employers, and (4) nonprofit employers. SustiNet G is part of the SustiNet Plan but separate from SustiNet coverage groups A to E. The authority is not required to simultaneously offer coverage to all of these employer categories and may offer coverage to different employer categories on a staggered basis.

Beginning January 1, 2014, the authority must offer coverage to all individuals and employers in Connecticut through SustiNet G, provided it has determined, after having conducted all necessary feasibility studies and risk assessments, that offering such coverage is financially viable and does not require General Fund appropriations.

The ongoing expenses of Sustinet G coverage must be funded solely by premium payments.

The authority must offer Sustinet G coverage (1) through any exchange established according to the ACA and (2) outside of any such exchange, including through insurance agents, brokers, and other methods of sale the authority approves.

Under the bill, a “municipal-related employer” is a property management, food service, or school transportation business that contracts with a nonstate public employer.

A “nonprofit employer” is (1) a nonprofit corporation organized under federal law (26 USC § 501) that contracts with the state or receives a portion of its funding from a local, state, or federal government or (2) a tax-exempt organization under federal law (26 USC § 501(c)(5)).

A “small employer” is (1) one qualified to purchase group coverage through the state’s health insurance exchange established according to the ACA and (2) any person, firm, corporation, limited liability company, partnership, or association actively engaged in business or self-employed for at least three consecutive months that, on at least 50% of its working days during the preceding 12 months, employed 50 or fewer employees most of whom are in Connecticut. When counting the number of employees, companies that are affiliates under state law or eligible to file a combined tax return are considered one employer. The bill specifies that a nonstate public employer is not a small employer.

Open Enrollment

Beginning January 1, 2012, the authority must offer Sustinet G coverage for minimum two-year periods to the extent feasible and, as of January 1, 2014, unless superceded by policies and procedures implementing the ACA. An employer can apply for renewal.

Initial open enrollment for Sustinet G for nonstate public employers is for coverage beginning January 1, 2012. Afterwards, open

enrollment periods for this group are for coverage beginning July 1. But beginning January 1, 2014, the authority can establish a different enrollment period to conform to the ACA.

The initial open enrollment period for municipal-related, small, and nonprofit employers is January 1 and July 1. January 1, 2012 is the earliest possible coverage date. But the authority must determine that offering this coverage is feasible.

The bill specifies that it does not require the authority to offer coverage from every Sustinet G plan to every employer seeking coverage.

Coverage Term, Renewal and Withdrawal

The bill requires the authority to develop procedures for an employer to (1) apply for plan participation, including procedures for employers that are currently self-insured or fully insured and (2) apply for renewal or withdrawal from coverage. The procedures must include the terms and conditions under which an employer may (1) withdraw before the benefit period ends and (2) obtain a refund for any premium payments to which the employer may be entitled. The procedures must provide that nonstate public employees covered under a collective bargaining agreement must withdraw in accordance with any applicable state collective bargaining laws for municipal employees and teachers.

Application Form

The bill requires the authority to create applications for Sustinet G coverage. The application must require the employer to disclose whether it will offer any other health plan to the employees who are offered the state plan.

Status as a Governmental Health Plan under Federal ERISA

The bill authorizes the authority to deny an employer coverage under Sustinet G if it determines that granting coverage will affect the plan's status as a governmental plan under ERISA. In addition to denying coverage, the authority must stop accepting applications from

municipal-related employers, nonprofits, and small employers. The authority must resume accepting applications if it determines that granting coverage will not affect the plan's ERISA status. The act requires the authority to publicly announce any decision to stop or resume accepting applications.

Taft-Hartley Exception

The bill prohibits an employee from enrolling in Sustinet G if he or she is covered through his or her employer under a health insurance plan or arrangement issued to, or in accordance with, a trust established through collective bargaining under the federal Labor Management Relations (i. e., "Taft-Hartley") Act.

Premiums

The authority sets Sustinet G premiums. All premiums paid by employers, employees, and retirees must be deposited into the Sustinet account. The authority can charge each employer participating in Sustinet G an administrative fee calculated on a per-member, per-month basis. Additionally, it can charge a fluctuating reserves fee in an amount the authority deems necessary to ensure adequate claims reserve. Employers must pay on a monthly basis the amount the authority determines for employee and retiree coverage. An employer can require each covered employee to contribute a portion of the cost of coverage, subject to any applicable collective bargaining agreement.

The authority can adjust premium rates for small employers, established on a community rate basis, to reflect one or more of the following: age, gender, geographic area, industry, group size, administrative cost savings related to administration of an association group plan or the Municipal Employee Health Insurance Plan (MEHIP), savings from a reduction in the profit of a carrier who writes small business plans or arrangements for an association group plan or a plan according to MEHIP, and family composition.

Penalties for Late Payment

The bill sets the same time frames for payment of premiums and

penalties for noncompliance as described above under the nonstate public employer coverage under the state employees health plan, except that the authority, rather than the comptroller, is the entity authorized to act. It also permits the authority to direct the treasurer or state agencies to withhold state money from a nonstate public employer that fails to pay premiums.

SustiNet G is Not an Unauthorized Insurer or MEWA

The bill specifies that SustiNet G is not an unauthorized insurer or a MEWA.

Conflict with Affordable Care Act

The bill specifies that, beginning January 1, 2014, any provision that conflicts with the ACA, as implemented by the state's health insurance exchange, does not apply to the sale of SustiNet plan coverage to employers through the exchange.

§§ 16,17—SUSTINET PLAN BENEFITS AND COST-SHARING

Plan Benefits

The bill requires the authority to establish benefits for all SustiNet plans offered on and outside the exchange. Benefits must be approved by the authority's board of directors. But no change to benefits for state employees can take effect until SEBAC consents in writing to incorporate the change into its agreement with the state and no changes to enrollee benefits in Medicaid; HUSKY Plan, Part A and B; HUSKY Plus; or Charter Oak can occur unless the change conforms to state and federal law.

SustiNet plans sold on the exchange must be designed to at least meet any benefit requirements to sell insurance on an exchange developed according to the ACA. SustiNet plan benefits must include mental health benefits equal to physical health benefits, vision care, and dental coverage comparable in scope to the median coverage provided by large employers in the Northeast states (as defined by the U.S. Census Bureau). In defining large employers, the authority must consider the capacity of available data to provide, without great cost, reliable estimates of median dental coverage such employers offer. The

authority must review and update benefits at least every two years and base benefit changes on medical evidence and scientific literature.

Under the bill, the Sustinet Plan must cover state health insurance mandates to the same extent as health plans sold on the state exchange must require coverage.

The authority must also take steps necessary to promote smoking cessation.

Cost-Sharing Requirements

The authority must establish cost-sharing requirements, which may include deductibles, copayments, and coinsurance for Sustinet Plans E and G. Any cost-sharing requirements established must first be approved by the board of directors. No change to the cost-sharing requirements for state employees is effective until SEBAC gives its written consent. Medicaid, HUSKY Plan, Part A and Part B, HUSKY Plus, and Charter Oak Health Plan cost-sharing provisions must not be established by the authority but instead must be established pursuant to the general statutes. Cost-sharing requirements may vary depending on the type of provider. The Sustinet Plan cannot impose copayments for preventive care, well-baby and well-child visits, prenatal care, annual physical exams, immunizations, or health screenings.

Cost-sharing requirements established by the authority must conform with the ACA's cost-sharing requirements.

Sustinet Plan providers are subject to the state's unfair billing practices law and cannot balance-bill Sustinet Plan members.

§ 19—AUDIT REPORTS

The bill requires the authority board of directors to provide the Appropriations, Public Health, Human Services, and Insurance and Real Estate committees with a copy of each audit of the authority done by an independent auditing firm, within seven days after the board receives the audit.

§§ 21-24—TECHNICAL CHANGES

These sections make technical and conforming changes concerning the authority's status as a quasi-public entity.

§ 25—REPEALED SECTIONS

The bill repeals the existing statutes on Sustinet, originally passed as PA 09-148. That act established a nine-member Sustinet Health Partnership board of directors that had to make legislative recommendations, by January 1, 2011, on the details and implementation of the Sustinet Plan. The act specified that the recommendations had to address:

1. establishment of a public authority or other entity with the power to contract with insurers and health care providers, develop health care infrastructure, set reimbursement rates, create advisory committees, and encourage the use of health information technology;
2. provisions for the phased-in offering of the Sustinet Plan to state employees and retirees, HUSKY A and B beneficiaries, people without employer-sponsored insurance (ESI), people with unaffordable ESI, small and large employers, and others;
3. guidelines for developing a model benefits package; and
4. public outreach and methods of identifying uninsured citizens.

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

The act also created task forces addressing obesity, tobacco usage, and the health care workforce.

BACKGROUND

Health Insurance Exchanges and Related Bills

The ACA (§ 1311) requires the establishment of state or regional

health insurance exchanges by January 1, 2014. Regional exchanges can be multistate or within part of a state. States choosing not to establish exchanges will rely on a federally operated exchange. An exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that allows for easy comparison of available plan options based on price, benefits and services, and quality.

There are three exchange-related bills currently under consideration in the General Assembly. SB 921 and HB 6323 were each reported favorably by the Insurance and Real Estate Committee to the Government Administration and Elections Committee on March 10. SB 1204 was reported favorably by the Public Health Committee on March 30.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute Change of Reference
Yea 16 Nay 10 (03/07/2011)

Insurance and Real Estate Committee

Joint Favorable Change of Reference
Yea 9 Nay 7 (03/10/2011)

Human Services Committee

Joint Favorable
Yea 12 Nay 6 (03/17/2011)