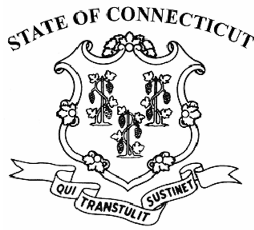

House of Representatives

General Assembly

File No. 341

January Session, 2011

Substitute House Bill No. 6305

House of Representatives, April 4, 2011

The Committee on Human Services reported through REP. TERCYAK of the 26th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING IMPLEMENTATION OF THE SUSTINET PLAN.

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

1 Section 1. (NEW) (*Effective from passage*) It is declared that, for the
2 benefit of the people of the state, the increase of their welfare and
3 prosperity and the improvement of their health and living conditions,
4 it is essential that this and future generations be given the fullest
5 opportunity to obtain health care that is universal, continuous,
6 affordable, sustainable, and that enhances health and well-being by
7 promoting access to high-quality health care that is effective, efficient,
8 safe, timely, patient-centered and equitable and therefore the SustiNet
9 Plan and its governing authority are established herein.

10 Sec. 2. (NEW) (*Effective from passage*) As used in sections 1 to 6,
11 inclusive, of this act, section 17b-261 of the general statutes, as
12 amended by this act, section 8 of this act, section 17b-90 of the general
13 statutes, as amended by this act, sections 10 to 17, inclusive, of this act,
14 section 19a-750 of the general statutes, as amended by this act, section
15 19 of this act, section 1-79 of the general statutes, as amended by this

16 act, section 1-120 of the general statutes, as amended by this act, and
17 sections 1-124 and 1-125 of the general statutes, as amended by this act:

18 (1) "Authority" or "SustiNet Authority", unless the context otherwise
19 requires, means the SustiNet Plan Authority established pursuant to
20 section 3 of this act;

21 (2) "Affordable Care Act" means the Patient Protection and
22 Affordable Care Act, P.L. 111-148, as amended from time to time;

23 (3) "Board of directors" or "board" means the board of directors for
24 the SustiNet Plan Authority, established pursuant to section 3 of this
25 act;

26 (4) "Exchange" means a health insurance exchange established for
27 the state pursuant to the provisions of Section 1311 of the Affordable
28 Care Act;

29 (5) "Health Care Cost Containment Committee" means the
30 committee established pursuant to the ratified agreement between the
31 state and State Employees' Bargaining Agent Coalition pursuant to
32 subsection (f) of section 5-278 of the general statutes;

33 (6) "Municipal-related employee" means any employee of a
34 municipal-related employer;

35 (7) "Municipal-related employer" means any property management
36 business, food service business or school transportation business that
37 is a party to a contract with a nonstate public employer;

38 (8) "Nonprofit employee" means any employee of a nonprofit
39 employer;

40 (9) "Nonprofit employer" means a nonprofit corporation, as defined
41 in subparagraph (B) of subdivision (7) of subsection (i) of section 5-259
42 of the general statutes;

43 (10) "Nonstate public employee" means any employee or elected
44 officer of a nonstate public employer;

45 (11) "Nonstate public employer" means a municipality or other
46 political subdivision of the state, including a board of education, quasi-
47 public agency or public library;

48 (12) "Northeast states" means the Northeast states, as defined by the
49 United States Census Bureau;

50 (13) "Patient-centered medical home" has the same meaning as set
51 forth in Section 3502 of the Affordable Care Act;

52 (14) "Small employer employee" means any employee of a small
53 employer;

54 (15) "Small employer" means an employer that is qualified to
55 purchase group coverage through a health insurance exchange
56 established in this state pursuant to the Affordable Care Act and any
57 person, firm, corporation, limited liability company, partnership or
58 association actively engaged in business or self-employed for at least
59 three consecutive months that, on at least fifty per cent of its working
60 days during the preceding twelve months, employed no more than
61 fifty employees, the majority of whom were employed within this
62 state. "Small employer" does not include a nonstate public employer.
63 In determining the number of eligible employees, companies that are
64 affiliates, as defined in section 33-840 of the general statutes, or that are
65 eligible to file a combined tax return under chapter 208 of the general
66 statutes, shall be considered one employer;

67 (16) "State employee plan" or "state plan" means a self-insured
68 group health care benefits plan established under subsection (m) of
69 section 5-259 of the general statutes; and

70 (17) "SustiNet Plan" or "plan", unless the context otherwise requires,
71 means a health insurance program that consists of multiple,
72 coordinated individual health insurance plans that provide or offer,
73 over a phased-in period of time, health insurance products to state
74 employees, Medicaid enrollees, HUSKY Plan, Part A and Part B
75 enrollees, HUSKY Plus enrollees, municipalities, municipal-related

76 employers, nonprofit employers, small employers, other employers
77 and individuals in the state and which, with respect to all health plans
78 offered, implements innovative, cost-controlling mechanisms and
79 measures to improve the quality of health care services and improve
80 the health of SustiNet Plan enrollees.

81 Sec. 3. (NEW) (*Effective from passage*) (a) There is hereby established
82 and created a body politic and corporate, constituting a public
83 instrumentality and political subdivision of the state of Connecticut
84 established and created for the performance of an essential public and
85 governmental function, to be known as the SustiNet Plan Authority.
86 The SustiNet Plan Authority is empowered to carry out the purposes
87 of the SustiNet Plan, which are hereby determined to be public
88 purposes for which public funds may be expended. The authority shall
89 not be construed to be a department, institution or agency of the state.

90 (b) The powers of the authority shall be vested in and exercised by a
91 board of directors, which shall consist of fifteen directors, appointed
92 on or before September 1, 2011, as follows: The Comptroller, or the
93 Comptroller's designee, and the Commissioner of Social Services, or
94 the commissioner's designee, shall serve as ex-officio voting members
95 of the board; three appointed by the Governor, one of whom shall be a
96 primary care physician who is in active practice, one of whom shall be
97 knowledgeable and experienced in measuring health care quality and
98 one of whom shall have expertise in health care administration; two
99 appointed by the president pro tempore of the Senate, one of whom
100 shall be a representative of hospitals and one of whom shall be a
101 SustiNet Plan member; two appointed by the speaker of the House of
102 Representatives, one of whom shall be a small employer and one of
103 whom shall be a SustiNet Plan member; one appointed by the majority
104 leader of the Senate, who shall be a representative of organized labor;
105 one appointed by the majority leader of the House of Representatives,
106 who shall represent a nonprofit health care center; one appointed by
107 the minority leader of the Senate, who shall be an oral health care
108 provider; and one appointed by the minority leader of the House of
109 Representatives, who shall be a mental health advocate. Thereafter, the

110 thirteen board of directors appointed in accordance with the
111 provisions of this subsection shall, by majority vote, appoint two
112 additional directors to the board. Any person previously appointed to
113 the SustiNet Health Partnership board of directors may be appointed
114 to the board of directors as provided for in this subsection.

115 (c) Commencing on September 1, 2011, the three directors initially
116 appointed by the Governor and the two directors initially appointed
117 pursuant to a vote of the board shall serve a term of four years. The
118 four directors initially appointed by the speaker of the House of
119 Representatives and the president pro tempore of the Senate shall
120 serve a term of three years. The four directors initially appointed by
121 the majority and minority leaders of the House of Representatives and
122 the majority and minority leaders of the Senate shall serve a term of
123 two years. Thereafter, all members shall be appointed for a term of
124 four years commencing on September first of the year of the
125 appointment. Each director shall serve at the pleasure of his or her
126 appointing authority but no longer than the term of office of the
127 appointing authority or until the director's successor is appointed and
128 qualified, whichever is longer, but in no case may a director serve for
129 longer than three months after the term of his or her appointing
130 authority.

131 (d) To qualify as a member of the board of directors of the authority,
132 each director of the SustiNet Plan Authority before entering upon his
133 or her duties shall take and subscribe the oath or affirmation required
134 by article XI, section 1, of the State Constitution. A record of each such
135 oath shall be filed in the office of the Secretary of the State. Meetings of
136 the board of directors shall be held at such times as shall be specified
137 in the bylaws adopted by the board and at such other time or times as
138 the chairperson deems necessary.

139 (e) There shall be two chairpersons of the board selected from the
140 fifteen members, one of whom shall be appointed by the Governor,
141 and one of whom shall be appointed jointly by the president pro
142 tempore of the Senate and the speaker of the House of Representatives.

143 The chairpersons shall be appointed with the advice and consent of
144 both houses of the General Assembly. The board shall annually elect
145 two of its members to serve as vice chairpersons.

146 (f) Appointed directors may not designate a representative to
147 perform in their absence their respective duties under this section and
148 sections 4, 11, 16, 17 and 19 of this act. Any appointed director who
149 fails to attend three consecutive meetings of the board or who fails to
150 attend fifty per cent of all meetings of the board held during any
151 calendar year shall be deemed to have resigned from the board. Any
152 appointed director may be removed by his or her appointing authority
153 for misfeasance, malfeasance or willful neglect of duty as determined
154 in the sole discretion of the appointing authority. Any appointing
155 authority shall fill any vacancy for the unexpired term of a director
156 appointed by such authority and said director may be reappointed for
157 a full term and subsequent terms. In the event that an appointing
158 authority fails to make an initial appointment to the board or an
159 appointment to fill a board vacancy within ninety days of the date of
160 the vacancy, the appointed directors, by majority vote, shall make such
161 appointment to the board.

162 (g) Nine directors of the authority shall constitute a quorum for the
163 transaction of any business or the exercise of any power of the
164 authority. For the transaction of any business or the exercise of any
165 power of the authority, the authority may act by a majority of the
166 directors present at any meeting at which a quorum is in attendance.
167 No vacancy in the membership of the board of directors shall impair
168 the right of such directors to exercise all the rights and perform all the
169 duties of the board. Any action taken by the board under the
170 provisions of this section and sections 4, 11, 16, 17 and 19 of this act
171 may be authorized by resolution approved by a majority of the
172 directors present at any regular or special meeting, which resolution
173 shall take effect immediately and need not be published or posted.

174 (h) The board of directors shall receive no compensation for the
175 performance of their official duties, except that each director shall be

176 entitled to reimbursement for such director's actual and necessary
177 expenses incurred during the performance of such director's official
178 duties.

179 (i) The board may delegate to three or more directors such board
180 powers and duties as it may deem necessary and proper. The board
181 shall establish such committees, subcommittees or other entities as it
182 deems necessary to further the purposes of the authority, including,
183 but not limited to, a finance committee.

184 (j) Notwithstanding any provision of the general statutes, it shall not
185 be or constitute a conflict of interest for a director, officer or employee
186 of an institution or business entity, including a health care institution,
187 or for any person having a financial interest in such an institution, to
188 serve as a member of the board of directors of the authority; provided
189 such director, officer, employee or person shall abstain from
190 deliberation, action and vote by the board under sections 4, 7, 11, 16, 17
191 and 19 of this act, in specific respect to the institution or business entity
192 of which such member is a director, officer or employee or in which
193 such director has a financial interest.

194 (k) Each member of the board of directors of the authority shall
195 execute a surety bond in the penal sum of fifty thousand dollars, or, in
196 lieu thereof, the chairpersons of the board shall execute a blanket
197 position bond covering each member of the board of directors and the
198 executive director and the employees of the authority, each surety
199 bond to be conditioned upon the faithful performance of the duties of
200 the office or offices covered, to be executed by a surety company
201 authorized to transact business in this state as surety and to be
202 approved by the Attorney General and filed in the office of the
203 Secretary of the State. The cost of each such bond shall be paid by the
204 authority.

205 (l) The board shall adopt written procedures, in accordance with the
206 provisions of section 1-121 of the general statutes, for: (1) Adopting an
207 annual budget and plan of operations, including a requirement of
208 board approval before the budget or plan may take effect; (2) hiring,

209 dismissing, promoting and compensating employees of the authority,
210 including an affirmative action policy and a requirement of approval
211 by the board or by the executive director of the authority, acting in
212 accordance with the directives of the board, before a position may be
213 created or a vacancy filled; (3) acquiring real and personal property
214 and personal services, including a requirement of board approval for
215 any nonbudgeted expenditure in excess of five thousand dollars; (4)
216 contracting for financial, legal, and other professional services,
217 including a requirement that the authority solicit proposals at least
218 once every three years for each such service which it uses; and (5) the
219 use of surplus funds to the extent authorized under any provision of
220 the general statutes.

221 (m) The chairpersons of the board, in consultation with the board,
222 shall appoint an executive director of the authority. The executive
223 director of the authority shall not be a member of the board. The
224 executive director of the authority shall serve at the pleasure of the
225 board and receive such compensation as shall be fixed by the board.

226 (n) The executive director shall supervise the administrative affairs
227 and technical activities of the SustiNet Plan Authority in accordance
228 with the directives of the board. The executive director shall be exempt
229 from the classified service. The executive director shall attend all board
230 meetings and keep a record of the proceedings of the authority and
231 shall be custodian of all books, documents, and papers filed with the
232 authority and of the minute book or journal of the authority and of its
233 official seal. The executive director may give certificates under the
234 official seal of the authority to the effect that such copies are true
235 copies, and all persons dealing with the authority may rely upon such
236 certificates.

237 (o) The authority shall continue as long as it shall have legal
238 authority to exist pursuant to the general statutes and until its
239 existence is terminated by law. Upon the termination of the existence
240 of the authority, all its rights and properties shall pass to and be vested
241 in the state of Connecticut.

242 (p) The provisions of chapter 12 of the general statutes shall apply to
243 any officer, director, designee or employee appointed as a member,
244 director or officer of the authority.

245 (q) The authority shall be subject to chapter 14 of the general
246 statutes, except that the following items shall be exempt from said
247 chapter and not subject to disclosure: (1) The names and applications
248 of SustiNet Plan enrollees; (2) health information of any SustiNet Plan
249 applicant or enrollee; (3) information relating to provider negotiations
250 and provider compensation arrangements, provided information
251 relating to Medicaid, HUSKY Plan, Part A and Part B, HUSKY Plus
252 and the Charter Oak Health Plan shall be subject to disclosure under
253 chapter 14 of the general statutes; and (4) information exchanged
254 between the authority and the Departments of Social Services and
255 Public Health, the Insurance Department, the Comptroller and any
256 other relevant state agency pursuant to confidentiality agreements
257 entered into pursuant to the provisions of section 10 of this act.

258 Sec. 4. (NEW) (*Effective from passage*) (a) There is established the
259 SustiNet Plan Consumer Advisory Board. The advisory board shall
260 consist of seven SustiNet Plan consumers, who shall represent the
261 different populations served by the SustiNet Plan. Initially, the
262 advisory board shall consist of two chairpersons, appointed by the
263 chairpersons of the SustiNet Plan Authority board of directors, who
264 shall each serve a one-year term, but who may be reappointed as
265 chairpersons upon the expiration of the one-year term. The advisory
266 board chairpersons shall, not later than thirty days after being
267 appointed, establish procedures for appointing an additional five
268 consumers to the advisory board, who shall serve on a staggered term
269 basis and thereafter be appointed by the advisory board chairpersons.
270 Subsequent to the initial appointment of the advisory board,
271 consumers seeking to serve as successor board members shall be
272 selected to serve on the board by a majority vote of the existing
273 advisory board members. The advisory board shall develop, approve
274 and implement a board member selection process in accordance with
275 the provisions of this section. Not more than two members of the

276 advisory board may be professional consumer advocates.

277 (b) The advisory board shall be responsible for issuing consumer
278 impact statements which describe the general effects on consumers of
279 major actions, as determined by such board, taken by the SustiNet Plan
280 Authority board of directors. The advisory board shall prepare
281 consumer impact statements that shall accompany the publication of
282 decisions made by the board of directors concerning the SustiNet Plan.
283 The advisory board shall advise the SustiNet Plan Authority board of
284 directors on issues relating to SustiNet Plan consumers. The authority
285 may make staff available to assist advisory board meetings.

286 Sec. 5. (NEW) (*Effective from passage*) (a) The purposes of the
287 SustiNet Plan Authority shall be to promote access to high-quality
288 health care that is effective, efficient, safe, timely, patient-centered and
289 equitable, and for such purposes the authority is authorized and
290 empowered to:

291 (1) Have perpetual succession as a body politic and corporate and to
292 adopt bylaws for the regulation of its affairs and the conduct of its
293 business;

294 (2) Adopt an official seal and alter the same at pleasure;

295 (3) Maintain an office at such place or places as it may designate;

296 (4) Sue and be sued in its own name, and plead and be impleaded;

297 (5) Employ such assistants, agents and other employees as may be
298 necessary or desirable, and engage consultants, actuaries, attorneys
299 and appraisers as may be necessary or desirable to carry out its
300 purposes in accordance with sections 3 to 6, inclusive, of this act,
301 section 8 of this act, section 17b-90 of the general statutes, as amended
302 by this act, and sections 10 to 17, inclusive, of this act;

303 (6) Make and enter into all contracts and agreements necessary,
304 incidental or consistent with the purpose of sections 3 to 6, inclusive, of
305 this act, section 8 of this act, section 17b-90 of the general statutes, as

306 amended by this act, and sections 10 to 17, inclusive, of this act,
307 including, but not limited to, the ability to contract with one or more
308 insurers or other entities for administrative purposes, to perform such
309 services that include, but are not limited to, claims processing,
310 credentialing of providers, utilization management, care management,
311 disease management and customer service;

312 (7) Solicit bids from individual providers and provider
313 organizations and to arrange with insurers and others for access to
314 existing or new provider networks, and take such other steps to
315 provide all SustiNet Plan members with access to timely, high-quality
316 health care throughout the state and, in appropriate cases, health care
317 that is outside the state's borders;

318 (8) Enter into agreements with any state agency to carry out the
319 purposes of sections 3 to 6, inclusive, of this act, section 8 of this act,
320 section 17b-90 of the general statutes, as amended by this act, and
321 sections 10 to 17, inclusive, of this act;

322 (9) Accept from the state financial assistance, revenues or the right
323 to receive revenues with respect to any program under the supervision
324 of the authority;

325 (10) Solicit, receive and accept aid, grants or contributions from any
326 source of money, property, labor or other things of value, to be held,
327 used and applied to carry out the purposes of sections 3 to 6, inclusive,
328 of this act, section 8 of this act, section 17b-90 of the general statutes, as
329 amended by this act, and sections 10 to 17, inclusive, of this act, subject
330 to such conditions upon which such aid, grants and contributions may
331 be made, including, but not limited to, gifts or grants from any
332 philanthropic organization, department, agency or instrumentality of
333 the United States or this state;

334 (11) Acquire, lease, purchase, own, manage, hold and dispose of real
335 property, and lease, convey or deal in or enter into agreements with
336 respect to such property on any terms necessary or incidental to the
337 carrying out of these purposes; provided, all such acquisitions of real

338 property for the authority's own use with amounts appropriated by
339 the state to the authority or with the proceeds of bonds supported by
340 the full faith and credit of the state shall be subject to the approval of
341 the Secretary of the Office of Policy and Management and the
342 provisions of section 4b-23 of the general statutes;

343 (12) Procure insurance against any liability or loss in connection
344 with its property and other assets, in such amounts and from such
345 insurers as it deems desirable;

346 (13) Purchase reinsurance or stop loss coverage, to set aside
347 reserves, or to take other prudent steps that avoid excess exposure to
348 risk in the authority's administration of health insurance plans;

349 (13) Account for and audit funds of the authority and funds of any
350 recipients of funds from the authority;

351 (14) Establish SustiNet health care plans in accordance with the
352 provisions of sections 3 to 6, inclusive, of this act, section 17b-261 of the
353 general statutes, as amended by this act, section 8 of this act, section
354 17b-90 of the general statutes, as amended by this act, and sections 10
355 to 17, inclusive, of this act;

356 (15) Commission surveys of consumers, employers and providers
357 on issues related to health care and health care coverage; and

358 (16) Do all acts and things necessary or convenient to carry out the
359 purposes of the authority.

360 (b) In addition to the powers vested with the authority pursuant to
361 subsection (a) of this section, the authority shall:

362 (1) Set payment methods for licensed health care providers that (A)
363 reflect evolving research and experience both within the state and
364 outside the state, (B) promote access to health care and patient health,
365 (C) prevent unnecessary health care spending, and (D) to the extent
366 feasible and consistent with delivery system and payment reforms,
367 ensure fair compensation to cover the reasonable cost of furnishing

368 necessary care;

369 (2) Facilitate joint contracting efforts on behalf of state agencies
370 wherever possible to achieve administrative savings, including, but
371 not limited to, by facilitating joint negotiation of any administrative
372 service organization contract to provide services to state employees,
373 Medicaid and HUSKY Plan, Part A and Part B, HUSKY Plus and
374 Charter Oak Health Plan enrollees, provided any such joint
375 administrative service organization contract shall not be effective until
376 the State Employee's Bargaining Agent Coalition has provided written
377 consent to the Comptroller that said coalition agrees to incorporate the
378 terms of any change into its collective bargaining agreement;

379 (3) Ensure that any agreement or contract entered into with an
380 administrative service organization to serve any SustiNet Plan
381 population does not contain payment mechanisms that provide an
382 inherent incentive to deny care;

383 (4) Negotiate on behalf of providers participating in the SustiNet
384 Plan to obtain discounted prices for vaccines and other health care
385 goods and services;

386 (5) Establish and maintain an Internet web site that provides for
387 timely posting of all public notices issued by the authority and such
388 other information as the authority deems relevant in educating the
389 public about the SustiNet Plan; and

390 (6) Make optimum use of opportunities created by the federal
391 government for securing new and increased federal funding,
392 including, but not limited to, increased reimbursement revenues.

393 Sec. 6. (NEW) (*Effective from passage*) (a) On and after January 1,
394 2012, the state employee plan, administered in accordance with the
395 provisions of section 5-259 of the general statutes, and the medical
396 assistance programs administered by the Department of Social
397 Services, in accordance with the provisions of chapter 319v of the
398 general statutes, including, the Medicaid program, HUSKY Plan, Part

399 A and Part B, HUSKY Plus programs, the Charter Oak Health Plan,
400 and the basic health program described in section 17b-261 of the
401 general statutes, as amended by this act, shall also be known as
402 SustiNet Plans. All SustiNet Plan members shall be provided with
403 member identification cards that have an identical design. SustiNet
404 Plan membership categories may be identified by discreet designations
405 on the member identification cards in a format prescribed by the
406 SustiNet Plan Authority.

407 (1) HUSKY Plan, Part A coverage, provided in accordance with the
408 provisions of sections 17b-261, as amended by this act, 17b-277 and
409 17b-306 to 17b-307, inclusive, of the general statutes, shall also be
410 known as SustiNet A.

411 (2) HUSKY Plan, Part B coverage, provided in accordance with the
412 provisions of sections 17b-290 to 17b-307, inclusive, of the general
413 statutes and HUSKY Plus benefits provided in accordance with section
414 17b-294a of the general statutes shall also be known as SustiNet B.

415 (3) Charter Oak Health Plan coverage provided in accordance with
416 the provisions of section 17b-311 of the general statutes shall also be
417 known as SustiNet C.

418 (4) Medicaid coverage, provided in accordance with the provisions
419 of chapter 319v of the general statutes shall also be known as SustiNet
420 D.

421 (5) State employee health plan coverage, provided in accordance
422 with the provisions of section 5-259 of the general statutes shall also be
423 known as SustiNet E.

424 (6) The health plan offered by the SustiNet Plan Authority pursuant
425 to subsection (f) of this section and section 15 of this act shall be known
426 as SustiNet G.

427 (b) Notwithstanding any provision of the general statutes, on and
428 after January 1, 2012, the state employee plan, administered in
429 accordance with the provisions of section 5-259 of the general statutes,

430 shall be part of the SustiNet Plan and shall also be known as SustiNet
431 E. The Comptroller shall administer the state employee plan in
432 accordance with rules established by the SustiNet Plan Authority and
433 in accordance with terms for which written consent has been provided
434 as prescribed in subsection (c) of this section. The authority may
435 establish rules concerning benefits, cost-sharing, utilization
436 management, care coordination, disease management, evidence-based
437 best practices, health care delivery systems, health care pilot programs,
438 provider payment methods, provider network management, provider
439 credentialing and customer service. On and after January 1, 2012, the
440 Comptroller shall continue to procure health insurance in accordance
441 with (1) section 5-259 of the general statutes for state employees and
442 state retirees; and (2) direction from the authority, provided the
443 Comptroller may jointly negotiate agreements with other agencies for
444 services in accordance with sections 10 and 11 of this act. The
445 Comptroller shall continue to make deductions for state employees
446 and to enroll and disenroll employees and retirees and may administer
447 customer relations for such employees and retirees. The Health Care
448 Cost Containment Committee shall continue to advise the Office of the
449 Comptroller on issues relating to state employee health care.

450 (c) No change in the terms of the state employee health insurance
451 plan shall be effective until the State Employees' Bargaining Agent
452 Coalition has provided written consent to the Comptroller that said
453 coalition agrees to incorporate the terms of any change into its
454 collective bargaining agreement.

455 (d) Notwithstanding any provision of the general statutes and to the
456 extent permitted by federal law, on and after January 1, 2012, the
457 Department of Social Services, which shall remain as the single state
458 agency administering the Medicaid program, HUSKY Plan, Part A and
459 Part B, HUSKY Plus programs and the Charter Oak Health Plan, may
460 immediately implement recommendations from the SustiNet Plan
461 Authority concerning the administration of such programs, including,
462 but not limited to, rules concerning utilization management, health
463 care coordination, disease management, evidence-based best practices,

464 health care delivery systems, provider payment methods, provider
465 network management, provider credentialing, pilot programs and
466 customer services. At the earliest date feasible, the department shall
467 contract with the SustiNet Plan Authority to provide or manage the
468 provision of all covered health care services to beneficiaries of the
469 Medicaid program, HUSKY Plan, Parts A and B, HUSKY Plus
470 programs and the Charter Oak Health Plan. The department shall
471 immediately seek any federal approval necessary to implement this
472 section, including, but not limited to, delivery system and payment
473 reforms recommended or implemented by the SustiNet Plan
474 Authority. The SustiNet Plan Authority shall not be permitted to
475 establish or amend requirements relating to the Medicaid program,
476 HUSKY Plan, Part A and Part B, HUSKY Plus programs or Charter
477 Oak Health Plan with respect to enrollment, eligibility, cost-sharing,
478 administrative appeal rights, and provider auditing; requirements
479 concerning such matters shall continue to be administered by the
480 department in accordance with applicable statutory requirements.
481 Notwithstanding any provision of the general statutes, on and after
482 January 1, 2012, the Commissioner of Social Services may jointly
483 negotiate agreements with other state agencies for services in
484 accordance with sections 10 and 11 of this act.

485 (e) Notwithstanding the provisions of title 38a of the general
486 statutes, on and after July 1, 2011, the Comptroller shall offer coverage
487 under the state employee plan to nonstate public employers and their
488 retirees, if applicable, in accordance with section 13 of this act,
489 provided the Comptroller receives an application from such nonstate
490 public employer and the application is approved in accordance with
491 section 13 of this act. The Comptroller shall not offer coverage under
492 the state employee plan pursuant to this subsection until the State
493 Employees' Bargaining Agent Coalition has provided written consent
494 to the Comptroller that said coalition agrees to incorporate the terms of
495 such coverage into its collective bargaining agreement.

496 (f) (1) At the earliest feasible date, on and after January 1, 2012,
497 notwithstanding the provisions of title 38a of the general statutes, the

498 authority, as feasible, shall offer coverage under a new, independent
499 coverage group, known as "SustiNet G", to employees and retirees of
500 the following employer categories who request such coverage and
501 whose application is approved in accordance with section 15 of this
502 act: (A) Nonstate public employers, (B) municipal-related employers,
503 (C) small employers, and (D) nonprofit employers. SustiNet G shall be
504 a part of the SustiNet Plan but shall be separate from SustiNet
505 coverage groups A to E, inclusive. Nothing in this subdivision shall
506 require the authority to simultaneously offer coverage to all employer
507 categories described in this subdivision. The authority may offer
508 coverage pursuant to this subdivision to different employer categories
509 on a staggered basis.

510 (2) On and after January 1, 2014, the authority shall offer coverage to
511 all individuals and employers in Connecticut through SustiNet G,
512 provided the authority has determined, after conducting all necessary
513 feasibility studies and risk assessments, that offering such coverage is
514 financially viable and does not require General Fund appropriations.
515 Notwithstanding the provisions of section 5 of this act, the ongoing
516 expenses of SustiNet G coverage shall be funded by premium
517 payments without recourse to any appropriated fund.

518 (3) The authority shall offer coverage pursuant to subdivisions (1)
519 and (2) of this subsection on any exchange established in accordance
520 with the provisions of the Affordable Care Act and outside of any such
521 exchange including through insurance agents, brokers and other
522 methods of sale approved by the authority.

523 Sec. 7. Subsection (a) of section 17b-261 of the general statutes is
524 repealed and the following is substituted in lieu thereof (*Effective from*
525 *passage*):

526 (a) Medical assistance shall be provided for any otherwise eligible
527 person whose income, including any available support from legally
528 liable relatives and the income of the person's spouse or dependent
529 child, is not more than one hundred forty-three per cent, pending
530 approval of a federal waiver applied for pursuant to subsection (e) of

531 this section, of the benefit amount paid to a person with no income
532 under the temporary family assistance program in the appropriate
533 region of residence and if such person is an institutionalized
534 individual as defined in Section 1917(c) of the Social Security Act, 42
535 USC 1396p(c), and has not made an assignment or transfer or other
536 disposition of property for less than fair market value for the purpose
537 of establishing eligibility for benefits or assistance under this section.
538 Any such disposition shall be treated in accordance with Section
539 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
540 property made on behalf of an applicant or recipient or the spouse of
541 an applicant or recipient by a guardian, conservator, person
542 authorized to make such disposition pursuant to a power of attorney
543 or other person so authorized by law shall be attributed to such
544 applicant, recipient or spouse. A disposition of property ordered by a
545 court shall be evaluated in accordance with the standards applied to
546 any other such disposition for the purpose of determining eligibility.
547 The commissioner shall establish the standards for eligibility for
548 medical assistance at one hundred forty-three per cent of the benefit
549 amount paid to a family unit of equal size with no income under the
550 temporary family assistance program in the appropriate region of
551 residence. Except as provided in section 17b-277, the medical
552 assistance program shall provide coverage to persons under the age of
553 nineteen with family income up to one hundred eighty-five per cent of
554 the federal poverty level without an asset limit and to persons under
555 the age of nineteen and their parents and needy caretaker relatives,
556 who qualify for coverage under [Section] Sections 1902
557 (a)(10)(A)(i)(VIII) and 1931 of the Social Security Act, with family
558 income up to one hundred eighty-five per cent of the federal poverty
559 level without an asset limit. Such levels shall be based on the regional
560 differences in such benefit amount, if applicable, unless such levels
561 based on regional differences are not in conformance with federal law.
562 Any income in excess of the applicable amounts shall be applied as
563 may be required by said federal law, and assistance shall be granted
564 for the balance of the cost of authorized medical assistance. The
565 Commissioner of Social Services shall provide applicants for assistance

566 under this section, at the time of application, with a written statement
567 advising them of (1) the effect of an assignment or transfer or other
568 disposition of property on eligibility for benefits or assistance, (2) the
569 effect that having income that exceeds the limits prescribed in this
570 subsection will have with respect to program eligibility, and (3) the
571 availability of, and eligibility for, services provided by the Nurturing
572 Families Network established pursuant to section 17b-751b. Persons
573 who are determined ineligible for assistance pursuant to this section
574 shall be provided a written statement notifying such persons of their
575 ineligibility and advising such persons of the availability of HUSKY
576 Plan, Part B health insurance benefits. On and after January 1, 2014,
577 medical assistance shall be provided to childless adults and parents
578 and needy caretaker relatives who qualify for coverage under Section
579 1931 of the Social Security Act, with family income up to one hundred
580 thirty-three per cent of the federal poverty level, without an asset test
581 and as determined in accordance with the provisions of the Affordable
582 Care Act. On and after January 1, 2014, the Commissioner of Social
583 Services shall implement the basic health program option in
584 accordance with the Affordable Care Act. On and after January 1, 2014,
585 all individuals with family income up to two hundred per cent of the
586 federal poverty level, as determined in accordance with the Affordable
587 Care Act, and who are ineligible for medical assistance pursuant to
588 Title XIX of the Social Security Act, shall be eligible for medical
589 assistance under the basic health program. Medical assistance
590 provided through the basic health program shall include all benefits,
591 limits on cost-sharing and other consumer safeguards that apply to
592 medical assistance provided in accordance with Title XIX of the Social
593 Security Act. Individuals enrolled in the basic health program shall
594 include parents with incomes above one hundred thirty-three per cent
595 of the federal poverty level, as determined under the Affordable Care
596 Act, who would otherwise qualify for HUSKY Plan, Part A and
597 individuals described in section 17b-257b. To the extent that federal
598 funds received pursuant to the basic health program exceed the cost of
599 medical assistance that would otherwise be provided to such enrollees
600 pursuant to Title XIX of the Social Security Act, the excess of such

601 federal funds shall be used to increase reimbursement rates for
602 providers serving individuals receiving benefits pursuant to this
603 section. The Commissioner of Social Services shall take all necessary
604 actions to maximize federal funding received in connection with the
605 establishment of a basic health program.

606 Sec. 8. (NEW) (*Effective from passage*) There is established an account
607 to be known as the "basic health program account" which shall be a
608 separate, nonlapsing account within the General Fund. The account
609 shall contain any moneys required by law to be deposited in the
610 account. Moneys in the account shall be expended by the SustiNet Plan
611 Authority for the purposes of operating the basic health program in
612 conformance with Section 1331 of the Affordable Care Act.

613 Sec. 9. Subsection (b) of section 17b-90 of the general statutes is
614 repealed and the following is substituted in lieu thereof (*Effective from*
615 *passage*):

616 (b) No person shall, except for purposes directly connected with the
617 administration of programs of the Department of Social Services and in
618 accordance with the regulations of the commissioner, solicit, disclose,
619 receive or make use of, or authorize, knowingly permit, participate in
620 or acquiesce in the use of, any list of the names of, or any information
621 concerning, persons applying for or receiving assistance from the
622 Department of Social Services or persons participating in a program
623 administered by said department, directly or indirectly derived from
624 the records, papers, files or communications of the state or its
625 subdivisions or agencies, or acquired in the course of the performance
626 of official duties. The Commissioner of Social Services shall disclose (1)
627 to any authorized representative of the Labor Commissioner such
628 information directly related to unemployment compensation,
629 administered pursuant to chapter 567 or information necessary for
630 implementation of sections 17b-688b, 17b-688c and 17b-688h and
631 section 122 of public act 97-2 of the June 18 special session, (2) to any
632 authorized representative of the Commissioner of Mental Health and
633 Addiction Services any information necessary for the implementation

634 and operation of the basic needs supplement program or for the
635 management of and payment for behavioral health services for
636 applicants for and recipients of state-administered general assistance,
637 (3) to any authorized representative of the Commissioner of
638 Administrative Services, or the Commissioner of Public Safety such
639 information as the state Commissioner of Social Services determines is
640 directly related to and necessary for the Department of Administrative
641 Services or the Department of Public Safety for purposes of performing
642 their functions of collecting social services recoveries and
643 overpayments or amounts due as support in social services cases,
644 investigating social services fraud or locating absent parents of public
645 assistance recipients, (4) to any authorized representative of the
646 Commissioner of Children and Families necessary information
647 concerning a child or the immediate family of a child receiving services
648 from the Department of Social Services, including safety net services, if
649 the Commissioner of Children and Families or the Commissioner of
650 Social Services has determined that imminent danger to such child's
651 health, safety or welfare exists to target the services of the family
652 services programs administered by the Department of Children and
653 Families, (5) to a town official or other contractor or authorized
654 representative of the Labor Commissioner such information
655 concerning an applicant for or a recipient of financial or medical
656 assistance under state-administered general assistance deemed
657 necessary by said commissioners to carry out their respective
658 responsibilities to serve such persons under the programs
659 administered by the Labor Department that are designed to serve
660 applicants for or recipients of state-administered general assistance, (6)
661 to any authorized representative of the Commissioner of Mental
662 Health and Addiction Services <u>any information necessary</u> for the
663 purposes of the behavioral health managed care program established
664 by section 17a-453, (7) to any authorized representative of the
665 Commissioner of Public Health <u>any information necessary</u> to carry out
666 his or her respective responsibilities under programs that regulate
667 child day care services or youth camps, **[**or**]** (8) to a health insurance
668 provider, in IV-D support cases, as defined in section 46b-231,

669 information concerning a child and the custodial parent of such child
670 that is necessary to enroll such child in a health insurance plan
671 available through such provider when the noncustodial parent of such
672 child is under court order to provide health insurance coverage but is
673 unable to provide such information, provided the Commissioner of
674 Social Services determines, after providing prior notice of the
675 disclosure to such custodial parent and an opportunity for such parent
676 to object, that such disclosure is in the best interests of the child, or (9)
677 to any authorized representative of the SustiNet Plan Authority such
678 information as may be necessary to carry out the purposes of the
679 authority. No such representative shall disclose any information
680 obtained pursuant to this section, except as specified in this section.
681 Any applicant for assistance provided through said department shall
682 be notified that, if and when such applicant receives benefits, the
683 department will be providing law enforcement officials with the
684 address of such applicant upon the request of any such official
685 pursuant to section 17b-16a.

686 Sec. 10. (NEW) (*Effective from passage*) The SustiNet Authority may
687 enter confidentiality agreements with the Departments of Social
688 Services and Public Health, the Insurance Department, the
689 Comptroller and any other relevant state agency that conform with the
690 Health Insurance Portability and Accountability Act of 1996, P.L. 104-
691 191 (HIPAA), as from time to time amended and other applicable
692 federal statutes, to obtain necessary information regarding SustiNet
693 Plan members. Any such information shall not be subject to chapter 14
694 of the general statutes.

695 Sec. 11. (NEW) (*Effective from passage*) (a) The SustiNet Plan shall be
696 administered to slow the growth of health care costs, improve the
697 quality of health care services and improve members' health outcomes.
698 To the extent consistent with applicable collective bargaining
699 agreements and the requirements of federal law, the authority may
700 implement, modify and supplement the delivery system and payment
701 reforms described in this section based on evolving evidence.

702 (b) The authority may work in cooperation with other public and
703 private entities to implement multi-payor initiatives that promote the
704 use of promising delivery system and payment reforms. In the context
705 of such cooperative work, the authority may work with any convener
706 authority established pursuant to section 20 of this act.

707 (c) In furtherance of the objectives set forth in subsection (a) of this
708 section, the SustiNet Plan Authority shall:

709 (1) Strongly encourage the use of patient-centered medical care by
710 implementing both primary care case management and patient-
711 centered medical homes for all SustiNet Plan members. Working in
712 coordination with other public and private entities as appropriate, the
713 authority shall develop provider capacity to function within these
714 patient-centered models of care. The authority may make or facilitate
715 grants and loans that (A) assist providers in transitioning to a primary
716 care case management system and patient-centered medical home
717 system, including, where appropriate, obtaining certification as a
718 patient-centered medical home; (B) provide technical assistance and
719 training for community teams certified or sponsored by the authority;
720 and (C) establish regional pilot programs. Any service delivery plan
721 established pursuant to this subdivision shall include provider
722 eligibility criteria that shall be met by any provider seeking to qualify
723 for reimbursement under a primary care case management system or
724 as a patient-centered medical home. A provider serving as a patient-
725 centered medical home in accordance with the provisions of this
726 subdivision shall provide services that include (i) assisting plan
727 members to safeguard and improve their own health by: (I) Advising
728 plan members with chronic health conditions of methods to monitor
729 and manage their own conditions; (II) working with plan members to
730 set and accomplish goals related to exercise, nutrition, use of tobacco
731 and other addictive substances, sleep and other behaviors that directly
732 affect such member's health; (III) implementing best practices to ensure
733 that plan members understand medical instructions and are able to
734 follow such directions; and (IV) providing translation services and
735 using culturally competent communication strategies in appropriate

736 cases; (ii) providing care coordination that includes: (I) Managing
737 transitions between home and the hospital; (II) proactive monitoring
738 that ensures that a plan member receives all recommended primary
739 and preventive care services; (III) the provision of basic mental health
740 care, including screening for depression, with referral relationships in
741 place for those plan members who require additional assistance; (IV)
742 strategies to address stresses that arise in the workplace, home, school
743 and the community, including coordination with and referrals to
744 available employee assistance programs; (V) referrals, in appropriate
745 cases, to nonmedical services such as housing and nutrition programs,
746 domestic violence resources and other support groups; and (VI) for a
747 plan member with complex health conditions that involve receiving
748 care from multiple providers, ensuring that such providers share
749 information about the plan member, as appropriate, and pursue a
750 single, integrated treatment plan on behalf of the plan member; and
751 (iii) providing readily accessible, twenty-four-hour consultative
752 services by telephone, secure electronic mail and quickly scheduled
753 office appointments for purposes that include reducing the need for
754 hospital emergency room visits;

755 (2) Establish provider payment mechanisms to encourage payment
756 for quality care and greater access to providers, including multi-payer
757 pilot programs, value-based purchasing pilot programs, bundled
758 payments, global payments, increasing and decreasing Medicaid
759 reimbursement for specific services or other innovations. Such
760 payment mechanisms may involve alternatives to utilization of fee-for-
761 service payments. To the extent warranted by available evidence, the
762 authority shall, not later than July 1, 2012, establish goals for increasing
763 the percentage of SustiNet expenditures made under alternative
764 payment methodologies. The authority shall develop methods to
765 measure the success of each alternative payment method;

766 (3) Provide community-based preventive care services, including,
767 but not limited to, immunizations, simple tests and health care
768 screenings at locations such as job sites, schools or other community
769 locations. The authority shall develop care standards applicable to the

770 providers of such services;

771 (4) Require that the SustiNet Plan be subject to the health insurance
772 mandates provided in chapter 700c of the general statutes;

773 (5) Develop recommendations for public education and outreach
774 campaigns to ensure that state residents are informed about the
775 SustiNet Plan and are encouraged to enroll in the plan. Such public
776 education and outreach campaign shall utilize community-based
777 organizations and shall include a focus on targeting populations that
778 are underserved by the health care delivery system. The public
779 education and outreach campaign shall be based on evidence of the
780 cost and effectiveness of similar efforts in this state and elsewhere.
781 Such campaign shall incorporate an ongoing evaluation of its
782 effectiveness, with corresponding changes in strategy, as needed;

783 (6) Work with other organizations within the state to minimize the
784 cost to providers of optimizing health information technology. The
785 authority shall take advantage of available federal resources while
786 leveraging the combined purchasing power of the state's health care
787 providers to obtain goods and services of lower cost and higher value.
788 Such efforts shall ensure that privacy and data security are fully
789 protected by all SustiNet Plan member data systems, including, but not
790 limited to, compliance with applicable federal requirements;

791 (7) Periodically review the authority's coverage of preventive care
792 based on the most current and reliable evidence available, including
793 results of SustiNet Plan prevention initiatives;

794 (8) Implement multi-year action plans to achieve measurable
795 objectives in areas such as the effective prevention and management of
796 chronic illness, reducing racial and ethnic disparities involving health
797 care and health outcomes, and reducing the number of state residents
798 without insurance. The authority should monitor the accomplishment
799 of such objectives and modify action plans as necessary;

800 (9) Within available appropriations, develop and implement

801 systematic policies and procedures that are used to identify, qualify for
802 subsidies, enroll and retain in coverage otherwise uninsured
803 individuals. Such policies and procedures may be developed and
804 implemented in collaboration with the Departments of Social Services
805 and Revenue Services, the Labor Department, the Comptroller, the
806 state's health insurance exchange and other local, state and federal
807 agencies, as well as individual health care providers, hospitals,
808 community health centers and other nongovernmental organizations,
809 as the authority deems appropriate;

810 (10) Establish a pay-for-performance system to reward health care
811 providers for improvements in health care quality and safety,
812 reductions in racial and ethnic disparities in health care access,
813 utilization, quality of care and health outcomes. Such pay-for-
814 performance systems may reward health care providers for (A)
815 making improvements as well as for meeting benchmarks, (B) having
816 an effective plan in place for preventing illness and improving health
817 status, and (C) caring for patients with the most complex and least
818 well-controlled conditions;

819 (11) Establish procedures concerning the use of preferred drug lists
820 and formularies;

821 (12) Establish procedures that prevent adverse selection;

822 (13) Pursue opportunities to negotiate discounts on vaccines or
823 other goods and services for SustiNet Plan providers; and

824 (14) Comply with the provisions of chapter 699a of the general
825 statutes concerning the preparation of consumer documents in plain
826 language.

827 (d) With respect to SustiNet G, the authority shall offer a variety of
828 SustiNet G plans to be sold on and off a health insurance exchange
829 developed for the state that offer a variety of benefits, out-of-pocket
830 costs and provider network arrangements, with each plan providing
831 comprehensive, commercial-style benefits, including vision, dental

832 care and parity of coverage for physical and mental health conditions.
833 Such plans shall include, to the extent feasible, patient-centered
834 medical homes, integration of physical and behavioral health care, and
835 emphasis on prevention that includes encouraging individual
836 responsibility for controllable health risks and other design features.

837 (e) In furtherance of the objectives set forth in subsection (a) of this
838 section, the SustiNet Plan Authority board of directors shall:

839 (1) Establish a standing committee that shall provide advice on
840 health information technology and establish a long-range plan to
841 optimize quality health care for plan members and slow cost growth
842 through the use of health information technology, which plan shall
843 encourage all SustiNet Plan providers to use interoperable electronic
844 health records to document and manage care;

845 (2) Establish one or more standing committees to address methods
846 to prevent and control chronic illnesses and significant health risks,
847 including, but not limited to, diabetes, hypertension, tobacco use,
848 childhood asthma and obesity. Such committees shall recommend
849 methods to (A) measure the quality of health care providers'
850 performance and improvement of the plan member's health, and (B)
851 measure and reduce racial and ethnic disparities concerning access to
852 and the provision of quality health care services;

853 (3) Establish a standing committee that shall develop
854 recommendations to (A) simplify procedures and paperwork for
855 providers, including, but not limited to, provider enrollment in the
856 SustiNet Plan, claims filing and utilization review procedures, and (B)
857 resolve systemic provider issues;

858 (4) Establish a standing committee that shall advise the board on
859 methods to attract primary care physicians, specialists and nurses to
860 the SustiNet Plan, and work in collaboration with other public and
861 private efforts to increase the capacity of the state's health care
862 workforce; and

863 (5) Implement policies and procedures to encourage the use of
864 evidence-based medicine. Such policies and procedures shall include
865 establishing a committee of clinicians to review and recommend for
866 adoption by the board, clinical care guidelines for the treatment of
867 particular diseases that are promulgated by national or international
868 authorities, after consultation with representatives of SustiNet Plan
869 providers and consumers. Any system that the board may adopt,
870 which rewards providers for meeting such guidelines, shall provide
871 mechanisms for documenting reasons to depart from such guidelines,
872 including, but not limited to, reasons related to an individual patient's
873 clinical condition.

874 Sec. 12. (NEW) (*Effective from passage*) (a) There is established an
875 account to be known as the "SustiNet account" which shall be a
876 separate, nonlapsing account within the General Fund. The account
877 shall contain any moneys required by law to be deposited in the
878 account. All SustiNet Plan premiums received pursuant to sections 13
879 and 15 of this act and all public or private funds provided to the
880 SustiNet Plan Authority shall be placed into the SustiNet account. The
881 Comptroller may make expenditures from the account at the direction
882 of the SustiNet Plan executive director.

883 (b) On or before January 1, 2012, the SustiNet Plan Authority's
884 executive director shall hire a consultant to determine existing state
885 expenditures on health care funding for each of the categories of
886 SustiNet Plan coverage. The executive director shall determine an
887 appropriate projection for normal health care cost increases for each
888 coverage group. If, after two years of SustiNet Plan operations, the
889 executive director can demonstrate to the satisfaction of the Secretary
890 of the Office of Policy and Management that the SustiNet Plan has
891 reduced overall per capita spending on enrolled coverage groups, the
892 amount of any such agreed to savings shall be placed into the SustiNet
893 account and may be used by the authority to make grants to providers,
894 increase provider rates or take other steps to improve the SustiNet
895 Plan in accordance with the provisions of sections 5, 7 and 11 of this
896 act.

897 Sec. 13. (NEW) (*Effective from passage*) (a) With respect to nonstate
898 public employers seeking coverage in the state employee plan, which
899 nonstate public employers are provided coverage in accordance with
900 section 6 of this act:

901 (1) On and after July 1, 2011, the Comptroller shall offer
902 participation in the state employee plan for not less than two-year
903 intervals, provided the Comptroller may modify such intervals on or
904 after January 1, 2014, if necessary, due to implementation of the
905 Affordable Care Act. An employer may apply for renewal prior to the
906 expiration of each interval.

907 (2) The Comptroller shall develop procedures by which:

908 (A) Such employers may apply to participate in the appropriate
909 plan, including procedures for nonstate public employers that are
910 currently self-insured and procedures for nonstate public employers
911 that are currently fully-insured; and

912 (B) Employers receiving coverage for their employees pursuant to
913 the state plan may (i) apply for renewal, or (ii) withdraw from such
914 coverage, including, but not limited to, the terms and conditions under
915 which such employers may withdraw prior to the expiration of the
916 interval and the procedure by which any premium payments such
917 employers may be entitled to shall be refunded. Any such procedures
918 shall provide that nonstate public employees covered by collective
919 bargaining shall withdraw from such coverage in accordance with
920 chapters 113 and 166 of the general statutes.

921 (b) The initial open enrollment for nonstate public employers
922 participating in the state employee plan shall be for coverage
923 beginning January 1, 2012. Thereafter, open enrollment for nonstate
924 public employers shall be for coverage periods beginning July first or
925 such other date as may be determined by the Comptroller.

926 (c) Nothing in this section or section 6 of this act shall require the
927 Comptroller to offer coverage from every plan offered under the state

928 employee plan to every employer seeking coverage under this section
929 or section 6 of this act.

930 (d) The Comptroller shall create applications for coverage under the
931 state employee plan. Such applications shall require a nonstate public
932 employer to disclose whether such employer will offer any other
933 health plan to the employees who are offered the state plan.

934 (e) No employee shall be enrolled in the state plan if such employee
935 is covered through such employee's employer by health insurance
936 plans or insurance arrangements issued to or in accordance with a
937 trust established pursuant to collective bargaining subject to the
938 federal Labor Management Relations Act.

939 (f) If the Comptroller determines that granting coverage to a
940 nonstate public employer under the state employee plan will affect
941 such plan's status as a governmental plan under the Employee
942 Retirement Income Security Act of 1974, as amended from time to
943 time, the Comptroller shall not grant coverage to such employer and
944 shall stop accepting applications for coverage from nonstate public
945 employers. The Comptroller shall resume accepting applications for
946 coverage under the state employee plan from such employers if the
947 Comptroller determines that granting coverage to such employers will
948 not affect such plan's status as a governmental plan under the
949 Employee Retirement Income Security Act of 1974, as amended from
950 time to time. The Comptroller shall make a public announcement of
951 the Comptroller's decision to stop or resume accepting applications for
952 coverage under the state employee plan.

953 (g) Nonstate public employers may join the state employee plan in
954 accordance with the provisions of this subsection.

955 (1) Notwithstanding any provision of the general statutes, initial
956 participation in the state employee plan by a nonstate public employer
957 shall be a permissive subject of collective bargaining and shall be
958 subject to binding interest arbitration only if the collective bargaining
959 agent and the employer mutually agree to bargain over such initial

960 participation. Such mutual agreement shall be in writing and signed by
961 authorized representatives of the collective bargaining agent and the
962 employer. Continuation in the state employee plan, after initial
963 participation, shall be a mandatory subject of bargaining and shall be
964 subject to binding interest arbitration in accordance with the same
965 procedures and standards that apply to any other mandatory subject
966 of bargaining pursuant to chapters 68, 113 and 166 of the general
967 statutes. For purposes of this section, a board of education and a
968 municipality shall be considered separate employers and shall submit
969 separate applications.

970 (2) (A) If a nonstate public employer submits an application in
971 accordance with this subsection for all of its employees, the
972 Comptroller shall accept such application for the next open enrollment.
973 The Comptroller shall provide written notification to such employer of
974 such acceptance and the date on which such coverage shall begin.

975 (B) If a nonstate public employer submits an application for less
976 than all of its employees, or indicates in the application that the
977 nonstate public employer will offer other health plans to employees
978 who are offered the state health plan, the Comptroller shall forward
979 such application to a health care actuary not later than five business
980 days after receiving such application. Such actuary may, not later than
981 sixty days after receiving such application, certify to the Comptroller
982 that the application will shift a significantly disproportional part of
983 such employer's employees' medical risks to the state employee plan,
984 and shall provide, in writing, the specific reasons for such finding,
985 including a summary of all information relied upon in making such a
986 finding. If the Comptroller receives such certification, the Comptroller
987 shall not provide coverage to such employer and shall provide written
988 notification and the specific reasons for such denial to such employer
989 and the Health Care Cost Containment Committee. If the Comptroller
990 does not receive such certification, the Comptroller shall accept such
991 application for the next open enrollment. The Comptroller shall
992 provide written notification to the nonstate public employer of such
993 acceptance and the date on which such coverage shall begin.

994 (C) The Comptroller shall consult with a health care actuary who
995 shall develop actuarial standards to be used to assess the shift in
996 medical risks of a nonstate public employer's employees to the state
997 employee plan. The Comptroller shall present such standards to the
998 Health Care Cost Containment Committee for its review and
999 evaluation prior to the use of such standards.

1000 (D) If a nonstate public employer included less than all of its
1001 employees in its application for coverage because of (i) the decision by
1002 individual employees to decline coverage from their employer for
1003 themselves or their dependents, or (ii) the employer's decision not to
1004 offer coverage to temporary, part-time or durational employees, the
1005 Comptroller shall not forward such employer's application to a health
1006 care actuary.

1007 (h) Nonstate employers eligible to seek coverage for their employees
1008 under the state employee plan, pursuant to this section and section 6 of
1009 this act, may seek such coverage for their retirees in accordance with
1010 this section. Premium payments for such coverage shall be remitted by
1011 the nonstate employer to the Comptroller in accordance with the
1012 provisions of this section.

1013 (i) (1) If a nonstate public employer seeks coverage for all of such
1014 employer's retirees in accordance with this section and all of such
1015 employer's employees as provided for in subsection (g) of this section,
1016 the Comptroller shall accept such application for the next open
1017 enrollment. The Comptroller shall provide written notification to such
1018 nonstate public employer of such acceptance and the date on which
1019 such coverage shall begin.

1020 (2) If a nonstate public employer seeks coverage for less than all of
1021 such employer's retirees, regardless of whether the employer is seeking
1022 coverage for all of such employer's active employees, the Comptroller
1023 shall forward such application to a health care actuary not later than
1024 five business days after receiving such application. Such actuary may,
1025 not later than sixty days after receiving such application, certify to the
1026 Comptroller that, with respect to such retirees, the application will

1027 shift a significantly disproportional part of an employer's retirees'
1028 medical risks to the state employee plan and shall provide in writing
1029 the specific reasons for such finding, including a summary of all
1030 information relied upon in making such a finding. If the Comptroller
1031 receives such certification, the Comptroller shall not provide coverage
1032 to such employer for such employer's retirees and the Comptroller,
1033 with respect to an application for state employee plan benefits, shall
1034 provide written notification and the specific reasons for such denial to
1035 such employer and the Health Care Cost Containment Committee, as
1036 defined in section 2 of this act, in the case of a rejected application for
1037 coverage under the state employee plan. If the Comptroller does not
1038 receive such certification, the Comptroller shall accept such application
1039 for the next open enrollment. The Comptroller or authority, as the case
1040 may be, shall provide written notification to such nonstate public
1041 employer of such acceptance and the date on which such coverage
1042 shall begin.

1043 (3) The Comptroller shall consult with a health care actuary who
1044 shall develop actuarial standards to be used to assess the shift in
1045 medical risks of a nonstate public employer's retirees to the state
1046 employee plan. The Comptroller shall present such standards to the
1047 Health Care Cost Containment Committee for its review and
1048 evaluation prior to the use of such standards.

1049 (4) If a nonstate public employer included less than all of its retirees
1050 in its application for coverage because of (A) the decision by individual
1051 retirees to decline health benefits or health insurance coverage from
1052 their employer for themselves or their dependents, or (B) the retiree's
1053 enrollment in Medicare, the Comptroller shall not forward such
1054 employer's application to a health care actuary.

1055 (5) Nothing in this subsection shall diminish any right to retiree
1056 health insurance pursuant to a collective bargaining agreement or any
1057 other provision of the general statutes.

1058 (j) All premiums paid by employers, employees and retirees
1059 pursuant to this section shall be deposited into the SustiNet account

1060 established pursuant to section 12 of this act.

1061 (k) Premium payments for the state employee plan shall be remitted
1062 by the employer to the Comptroller and shall be the same as those paid
1063 by the state, inclusive of any premiums paid by state employees and
1064 retired state employees, if applicable, except as otherwise provided in
1065 this section. The Comptroller may charge each nonstate public
1066 employer participating in the state plan an administrative fee
1067 calculated on a per member, per month basis. In addition, the
1068 Comptroller may charge a fluctuating reserves fee in an amount which
1069 the Comptroller deems necessary to ensure adequate claims reserves.

1070 (l) Each nonstate public employer shall pay monthly the amount
1071 determined by the Comptroller pursuant to this section for coverage of
1072 its employees or its employees and retirees, as appropriate. A nonstate
1073 employer may require each covered employee to contribute a portion
1074 of the cost of such employee's coverage under the plan, subject to any
1075 collective bargaining obligation applicable to such employer.

1076 (m) If any payment due by a nonstate public employer under this
1077 section is not submitted to the appropriate entity by the tenth day after
1078 the date such payment is due, interest to be paid by such employer
1079 shall be added to the amount due, retroactive to the date such payment
1080 was due, at the prevailing rate of interest as determined by the
1081 appropriate entity.

1082 (1) If a nonstate public employer fails to make premium payments
1083 as required by this section, the Comptroller may direct the State
1084 Treasurer, or any other officer of the state who is the custodian of any
1085 moneys made available by grant, allocation or appropriation payable
1086 to such nonstate public employer, to withhold the payment of such
1087 moneys until the amount of the premium or interest due has been paid
1088 to the Comptroller, or until the State Treasurer or such custodial officer
1089 determines that arrangements have been made, to the satisfaction of
1090 the State Treasurer, for the payment of such premium and interest.
1091 Such moneys shall not be withheld if such withholding will adversely
1092 affect the receipt of any federal grant or aid in connection with such

1093 moneys.

1094 (2) If no grant, allocation or appropriation is payable to such
1095 nonstate public employer or is not withheld, pursuant to subdivision
1096 (1) of this subsection, the Comptroller may terminate participation in
1097 the state employee plan by a nonstate public employer on the basis of
1098 nonpayment of premium, provided not less than ten days' advance
1099 notice is given to such employer. The nonstate public employer may
1100 continue the coverage and avoid the effect of the termination by
1101 remitting payment in full at any time prior to the effective date of
1102 termination.

1103 (3) The Comptroller may request the Attorney General to bring an
1104 action in the superior court for the judicial district of Hartford to
1105 recover any premium and interest costs or equitable relief from a
1106 terminated nonstate public employer.

1107 (n) The Comptroller may adopt regulations, in accordance with
1108 chapter 54 of the general statutes, to establish the procedures and
1109 criteria for any reviews or evaluations performed by the Health Care
1110 Cost Containment Committee pursuant to this section.

1111 (o) The SustiNet Plan Authority may adopt procedures necessary to
1112 carry out the provisions of this section in accordance with section 1-121
1113 of the general statutes.

1114 (p) The state employee plan shall not be deemed an unauthorized
1115 insurer, as defined in section 38a-1 of the general statutes, or a multiple
1116 employer welfare arrangement, as defined in Section 3 of the
1117 Employee Retirement Income Security Act of 1974, as amended from
1118 time to time.

1119 Sec. 14. (NEW) (*Effective from passage*) There is established a
1120 Nonstate Public Health Care Advisory Committee. The committee
1121 shall make advisory recommendations to the Health Care Cost
1122 Containment Committee, as defined in section 2 of this act, concerning
1123 health care coverage for nonstate public employees. The advisory

1124 committee shall consist of nonstate public employers and employees
1125 participating in the state plan and shall include the following members
1126 appointed by the Comptroller: (1) Three municipal employer
1127 representatives, one of whom represents towns with populations of
1128 one hundred thousand or more, one of whom represents towns with
1129 populations of at least twenty thousand but under one hundred
1130 thousand, and one of whom represents towns with populations under
1131 twenty thousand; (2) three municipal employee representatives, one of
1132 whom represents employees in towns with populations of one
1133 hundred thousand or more, one of whom represents employees in
1134 towns with populations of at least twenty thousand but under one
1135 hundred thousand, and one of whom represents employees in towns
1136 with populations under twenty thousand; (3) three board of education
1137 employers, one of whom represents towns with populations of one
1138 hundred thousand or more, one of whom represents towns with
1139 populations of at least twenty thousand but under one hundred
1140 thousand, and one of whom represents towns with populations under
1141 twenty thousand; and (4) three board of education employee
1142 representatives, one of whom represents towns with populations of
1143 one hundred thousand or more, one of whom represents towns with
1144 populations of at least twenty thousand but under one hundred
1145 thousand, and one of whom represents towns with populations under
1146 twenty thousand.

1147 Sec. 15. (NEW) (*Effective from passage*) (a) With respect to nonstate
1148 public employers, municipal-related employers, nonprofit employers
1149 and other employers, which are provided coverage in accordance with
1150 section 6 of this act under SustiNet G:

1151 (1) On and after January 1, 2012, the SustiNet Plan Authority shall
1152 offer participation in SustiNet G for not less than two-year intervals to
1153 the extent feasible and unless superseded by policies and procedures
1154 concerning the implementation of the Affordable Care Act on or after
1155 January 1, 2014. An employer may apply for renewal prior to the
1156 expiration of each interval.

1157 (2) The authority shall develop procedures by which:

1158 (A) Such employers may apply to participate in the plan, including
1159 procedures for employers that are currently self-insured and
1160 procedures for employers that are currently fully-insured; and

1161 (B) Employers receiving coverage for their employees pursuant to
1162 SustiNet G may (i) apply for renewal, or (ii) withdraw from such
1163 coverage, including, but not limited to, the terms and conditions under
1164 which such employers may withdraw prior to the expiration of the
1165 interval and the procedure by which any premium payments such
1166 employers may be entitled to shall be refunded. Any such procedures
1167 shall provide that nonstate public employees covered by collective
1168 bargaining shall withdraw from such coverage in accordance with
1169 chapters 113 and 166 of the general statutes.

1170 (b) (1) The initial open enrollment for nonstate public employers
1171 participating in SustiNet G shall be for coverage beginning January 1,
1172 2012. Thereafter, open enrollment for nonstate public employers shall
1173 be for coverage periods beginning July first, provided that on and after
1174 January 1, 2014, the authority may establish a different enrollment
1175 period to conform with implementation of the Affordable Care Act.

1176 (2) The initial open enrollment for municipal-related employers,
1177 small employers and nonprofit employers participating in SustiNet G
1178 shall be for coverage periods beginning January first and July first
1179 beginning no sooner than January 1, 2012, if the authority has
1180 determined that offering such coverage is feasible.

1181 (c) Nothing in this section or section 6 of this act shall require the
1182 authority to offer coverage to every employer seeking coverage under
1183 this section or section 6 of this act from every plan offered under
1184 SustiNet G.

1185 (d) The authority shall create applications for coverage for the
1186 members it serves. An application for participation in the SustiNet G
1187 shall require an employer to disclose whether the employer will offer

1188 any other health plan to the employees who are offered the state plan.

1189 (e) No employee shall be enrolled in SustiNet G if such employee is
1190 covered through such employee's employer by health insurance plans
1191 or insurance arrangements issued to or in accordance with a trust
1192 established pursuant to collective bargaining subject to the federal
1193 Labor Management Relations Act.

1194 (f) If the authority determines that granting coverage to an
1195 employer under SustiNet G will affect such plan's status as a
1196 governmental plan under the Employee Retirement Income Security
1197 Act of 1974, as amended from time to time, the authority shall not
1198 grant coverage to such employer and shall stop accepting applications
1199 for coverage from employers. The authority shall resume accepting
1200 applications for coverage under SustiNet G from such employers if the
1201 authority determines that granting coverage to such employers will
1202 not affect such plan's status as a governmental plan under the
1203 Employee Retirement Income Security Act of 1974, as amended from
1204 time to time. The authority shall make a public announcement of its
1205 decision to stop or resume accepting applications for coverage under
1206 SustiNet G.

1207 (g) All premiums paid by employers, employees and retirees
1208 pursuant to this section shall be deposited into the SustiNet account
1209 established pursuant to section 12 of this act.

1210 (h) Premium payments for SustiNet G shall be remitted by the
1211 employer to the authority and shall be the amount set by the authority.
1212 The authority may charge each employer participating in SustiNet G
1213 an administrative fee calculated on a per member, per month basis. In
1214 addition, the authority may charge a fluctuating reserves fee in an
1215 amount which the authority deems necessary to ensure adequate
1216 claims reserves.

1217 (i) The authority may adjust premium rates for small employers to
1218 reflect one or more of the characteristics set forth in subparagraph (A)
1219 of subdivision (5) of section 38a-567 of the general statutes.

1220 (j) Each employer shall pay monthly the amount determined by the
1221 authority pursuant to this section for coverage of its employees or its
1222 employees and retirees, as appropriate. An employer may require each
1223 covered employee to contribute a portion of the cost of such
1224 employee's coverage under the plan, subject to any collective
1225 bargaining obligation applicable to such employer.

1226 (k) If any payment due by an employer under this section is not
1227 submitted to the authority by the tenth day after the date such
1228 payment is due, or such other date as chosen by the authority, interest
1229 to be paid by such employer shall be added to the amount due,
1230 retroactive to the date such payment was due, at the prevailing rate of
1231 interest as determined by the appropriate entity.

1232 (l) The authority may terminate participation in SustiNet G by the
1233 employer on the basis of nonpayment of premium, provided not less
1234 than ten days' advance notice is given to such employer. The employer
1235 may continue the coverage and avoid the effect of the termination by
1236 remitting payment in full at any time prior to the effective date of
1237 termination.

1238 (2) (A) If a nonstate public employer fails to make premium
1239 payments as required by this section, the authority may direct the State
1240 Treasurer, or any other officer of the state who is the custodian of any
1241 moneys made available by grant, allocation or appropriation payable
1242 to such nonstate public employer, to withhold the payment of such
1243 moneys until the amount of the premium or interest due has been paid
1244 to the authority, or until the State Treasurer or such custodial officer
1245 determines that arrangements have been made, to the satisfaction of
1246 the State Treasurer, for the payment of such premium and interest.
1247 Such moneys shall not be withheld if such withholding will adversely
1248 affect the receipt of any federal grant or aid in connection with such
1249 moneys.

1250 (B) If no grant, allocation or appropriation is payable to such
1251 nonstate public employer or is not withheld, pursuant to
1252 subparagraph (A) of this subdivision, the authority may terminate

1253 participation in SustiNet G by a nonstate public employer on the basis
1254 of nonpayment of premium, provided not less than ten days' advance
1255 notice is given to such nonstate public employer. The nonstate public
1256 employer may continue the coverage and avoid the effect of the
1257 termination by remitting payment in full consistent with policies and
1258 procedures adopted by the authority.

1259 (l) The authority may request the Attorney General to bring an
1260 action in the superior court for the judicial district of Hartford to
1261 recover any premium and interest costs or equitable relief from a
1262 terminated employer.

1263 (m) SustiNet G shall not be deemed an unauthorized insurer, as
1264 defined in section 38a-1 of the general statutes, or a multiple employer
1265 welfare arrangement, as defined in Section 3 of the Employee
1266 Retirement Income Security Act of 1974, as amended from time to
1267 time.

1268 (n) On and after January 1, 2014, any provision of this section that is
1269 in conflict with the Affordable Care Act, as implemented by the health
1270 insurance exchange serving the state, shall not apply to the sale of
1271 SustiNet Plan coverage to employers through such exchange.

1272 Sec. 16. (NEW) (*Effective from passage*) (a) The SustiNet Plan
1273 Authority shall establish benefits for all SustiNet plans offered on and
1274 off the exchange, which shall be approved by the board of directors,
1275 provided no change to the benefits for state employees shall be
1276 effective until the State Employees' Bargaining Agent Coalition has
1277 provided its written consent to incorporate such change into its
1278 agreement with the state. There shall be no change to the benefits of
1279 Medicaid, HUSKY Plan, Part A and Part B, HUSKY Plus or Charter
1280 Oak Health Plan enrollees unless such change is in conformance with
1281 the provisions of the general statutes and federal law.

1282 (b) To the extent that health plans sold on a state established health
1283 insurance exchange require coverage of the benefits provided for in
1284 chapter 700c of the general statutes, the SustiNet Plan shall also

1285 include coverage of the benefits provided for in chapter 700c of the
1286 general statutes.

1287 (c) SustiNet plans that are to be sold on the exchange shall be
1288 designed to at least meet any benefit requirements to sell insurance on
1289 any exchange developed in accordance with the Affordable Care Act.
1290 SustiNet Plan benefits shall include, but not be limited to, mental
1291 health benefits that are equal to physical health benefits, vision care
1292 and dental care coverage that shall be comparable in scope to the
1293 median coverage provided by large employers in the Northeast states,
1294 provided, in defining large employers, the authority shall give
1295 consideration to the capacity of available data to yield, without
1296 substantial expense, reliable estimates of median dental coverage
1297 offered by such employers. The authority shall take steps necessary to
1298 promote the cessation of smoking.

1299 (d) The authority shall review and update benefits not less than
1300 every two years and shall base benefit changes on medical evidence
1301 and scientific literature.

1302 Sec. 17. (NEW) (*Effective from passage*) (a) The SustiNet Plan
1303 Authority shall establish cost-sharing requirements, which may
1304 include deductibles, copayments and coinsurance for SustiNet Plans E
1305 and G. Any cost-sharing requirements established by the authority
1306 shall first be approved by the SustiNet board of directors. No change
1307 to the cost-sharing requirements for state employees shall be effective
1308 until the State Employees' Bargaining Agent Coalition has provided its
1309 written consent to incorporate such change into its agreement with the
1310 state. Notwithstanding the provisions of this subsection, Medicaid,
1311 HUSKY Plan, Part A and Part B, HUSKY Plus and Charter Oak Health
1312 Plan cost-sharing provisions shall not be established by the authority
1313 but instead shall be established pursuant to the general statutes. Cost-
1314 sharing requirements may vary depending on the type of provider.
1315 Under the SustiNet Plan, there shall not be copayments for preventive
1316 care, well-baby and well-child visits, prenatal care, annual physical
1317 exams, immunizations or health screenings.

1318 (b) Cost-sharing requirements established by the authority pursuant
1319 to subsection (a) of this section shall be in conformance with the cost-
1320 sharing requirements established by the Affordable Care Act.

1321 (c) SustiNet Plan providers shall be subject to the provisions of
1322 section 20-7f of the general statutes and shall be prohibited from
1323 balance billing SustiNet Plan members.

1324 Sec. 18. Subdivision (1) of subsection (c) of section 19a-750 of the
1325 general statutes is repealed and the following is substituted in lieu
1326 thereof (*Effective from passage*):

1327 (c) (1) The Health Information Technology Exchange of Connecticut
1328 shall be managed by a board of directors. The board shall consist of the
1329 following members: The Lieutenant Governor, or his or her designee;
1330 the Commissioners of Public Health, Social Services and Consumer
1331 Protection, or their designees; the Chief Information Officer of the
1332 Department of Information Technology, or his or her designee; the
1333 executive director of the SustiNet Plan Authority, or his or her
1334 designee; three appointed by the Governor, one of whom shall be a
1335 representative of a medical research organization, one of whom shall
1336 be an insurer or representative of a health plan and one of whom shall
1337 be an attorney with background and experience in the field of privacy,
1338 health data security or patient rights; three appointed by the president
1339 pro tempore of the Senate, one of whom shall have background and
1340 experience with a private sector health information exchange or health
1341 information technology entity, one of whom shall have expertise in
1342 public health and one of whom shall be a physician licensed under
1343 chapter 370 who works in a practice of not more than ten physicians
1344 and who is not employed by a hospital, health network, health plan,
1345 health system, academic institution or university; three appointed by
1346 the speaker of the House of Representatives, one of whom shall be a
1347 representative of hospitals, an integrated delivery network or a
1348 hospital association, one of whom shall have expertise with federally
1349 qualified health centers and one of whom shall be a consumer or
1350 consumer advocate; one appointed by the majority leader of the

1351 Senate, who shall be a primary care physician whose practice utilizes
1352 electronic health records; one appointed by the majority leader of the
1353 House of Representatives, who shall be a consumer or consumer
1354 advocate; one appointed by the minority leader of the Senate, who
1355 shall be a pharmacist or a health care provider utilizing electronic
1356 health information exchange; and one appointed by the minority
1357 leader of the House of Representatives, who shall be a large employer
1358 or a representative of a business group. The Secretary of the Office of
1359 Policy and Management and the Healthcare Advocate, or their
1360 designees, shall be ex-officio, nonvoting members of the board. The
1361 Commissioner of Public Health, or his or her designee, shall serve as
1362 the chairperson of the board.

1363 Sec. 19. (NEW) (*Effective from passage*) The board of directors of the
1364 SustiNet Plan Authority shall submit to the joint standing committee of
1365 the General Assembly having cognizance of matters relating to
1366 appropriations, public health, human services and insurance and real
1367 estate a copy of each audit of the authority conducted by an
1368 independent auditing firm, not later than seven days after the audit is
1369 received by said board of directors.

1370 Sec. 20. (NEW) (*Effective from passage*) The Comptroller is authorized
1371 to serve as a convener authority for health care institutions, facilities
1372 and providers in the state. The Comptroller shall comply with all
1373 applicable federal law and regulations in the exercise of such
1374 authority. The Comptroller shall implement policies and procedures
1375 necessary to administer the provisions of this section while in the
1376 process of adopting such policies and procedures as regulations,
1377 provided the Comptroller prints notice of the intent to adopt the
1378 regulations in the Connecticut Law Journal not later than twenty days
1379 after the date of implementation of such policies and procedures.
1380 Policies and procedures implemented pursuant to this section shall be
1381 valid until the time final regulations are adopted.

1382 Sec. 21. Subsection (l) of section 1-79 of the general statutes is
1383 repealed and the following is substituted in lieu thereof (*Effective from*

1384 *passage*):

1385 (l) "Quasi-public agency" means the Connecticut Development
1386 Authority, Connecticut Innovations, Incorporated, Connecticut Health
1387 and Education Facilities Authority, Connecticut Higher Education
1388 Supplemental Loan Authority, Connecticut Housing Finance
1389 Authority, Connecticut Housing Authority, Connecticut Resources
1390 Recovery Authority, Lower Fairfield County Convention Center
1391 Authority, Capital City Economic Development Authority,
1392 Connecticut Lottery Corporation, **[**and**]** Health Information
1393 Technology Exchange of Connecticut and SustiNet Plan Authority.

1394 Sec. 22. Section 1-120 of the general statutes is repealed and the
1395 following is substituted in lieu thereof (*Effective from passage*):

1396 As used in sections 1-120 to 1-123, inclusive:

1397 (1) "Quasi-public agency" means the Connecticut Development
1398 Authority, Connecticut Innovations, Incorporated, Connecticut Health
1399 and Educational Facilities Authority, Connecticut Higher Education
1400 Supplemental Loan Authority, Connecticut Housing Finance
1401 Authority, Connecticut Housing Authority, Connecticut Resources
1402 Recovery Authority, Capital City Economic Development Authority,
1403 Connecticut Lottery Corporation, **[**and**]** Health Information
1404 Technology Exchange of Connecticut and SustiNet Plan Authority.

1405 (2) "Procedure" means each statement, by a quasi-public agency, of
1406 general applicability, without regard to its designation, that
1407 implements, interprets or prescribes law or policy, or describes the
1408 organization or procedure of any such agency. The term includes the
1409 amendment or repeal of a prior regulation, but does not include,
1410 unless otherwise provided by any provision of the general statutes, (A)
1411 statements concerning only the internal management of any agency
1412 and not affecting procedures available to the public and (B) intra-
1413 agency memoranda.

1414 (3) "Proposed procedure" means a proposal by a quasi-public

1415 agency under the provisions of section 1-121 for a new procedure or
1416 for a change in, addition to or repeal of an existing procedure.

1417 Sec. 23. Section 1-124 of the general statutes is repealed and the
1418 following is substituted in lieu thereof (*Effective from passage*):

1419 (a) The Connecticut Development Authority, the Connecticut
1420 Health and Educational Facilities Authority, the Connecticut Higher
1421 Education Supplemental Loan Authority, the Connecticut Housing
1422 Finance Authority, the Connecticut Housing Authority, the
1423 Connecticut Resources Recovery Authority, the Health Information
1424 Technology Exchange of Connecticut, [and] the Capital City Economic
1425 Development Authority <u>and the SustiNet Plan Authority</u> shall not
1426 borrow any money or issue any bonds or notes which are guaranteed
1427 by the state of Connecticut or for which there is a capital reserve fund
1428 of any kind which is in any way contributed to or guaranteed by the
1429 state of Connecticut until and unless such borrowing or issuance is
1430 approved by the State Treasurer or the Deputy State Treasurer
1431 appointed pursuant to section 3-12. The approval of the State Treasurer
1432 or said deputy shall be based on documentation provided by the
1433 authority that it has sufficient revenues to (1) pay the principal of and
1434 interest on the bonds and notes issued, (2) establish, increase and
1435 maintain any reserves deemed by the authority to be advisable to
1436 secure the payment of the principal of and interest on such bonds and
1437 notes, (3) pay the cost of maintaining, servicing and properly insuring
1438 the purpose for which the proceeds of the bonds and notes have been
1439 issued, if applicable, and (4) pay such other costs as may be required.

1440 (b) To the extent the Connecticut Development Authority,
1441 Connecticut Innovations, Incorporated, Connecticut Higher Education
1442 Supplemental Loan Authority, Connecticut Housing Finance
1443 Authority, Connecticut Housing Authority, Connecticut Resources
1444 Recovery Authority, Connecticut Health and Educational Facilities
1445 Authority, [the] Health Information Technology Exchange of
1446 Connecticut, [or the] Capital City Economic Development Authority <u>or</u>
1447 <u>SustiNet Plan Authority</u> is permitted by statute and determines to

1448 exercise any power to moderate interest rate fluctuations or enter into
1449 any investment or program of investment or contract respecting
1450 interest rates, currency, cash flow or other similar agreement,
1451 including, but not limited to, interest rate or currency swap
1452 agreements, the effect of which is to subject a capital reserve fund
1453 which is in any way contributed to or guaranteed by the state of
1454 Connecticut, to potential liability, such determination shall not be
1455 effective until and unless the State Treasurer or his or her deputy
1456 appointed pursuant to section 3-12 has approved such agreement or
1457 agreements. The approval of the State Treasurer or his or her deputy
1458 shall be based on documentation provided by the authority that it has
1459 sufficient revenues to meet the financial obligations associated with the
1460 agreement or agreements.

1461 Sec. 24. Section 1-125 of the general statutes is repealed and the
1462 following is substituted in lieu thereof (*Effective from passage*):

1463 The directors, officers and employees of the Connecticut
1464 Development Authority, Connecticut Innovations, Incorporated,
1465 Connecticut Higher Education Supplemental Loan Authority,
1466 Connecticut Housing Finance Authority, Connecticut Housing
1467 Authority, Connecticut Resources Recovery Authority, including ad
1468 hoc members of the Connecticut Resources Recovery Authority,
1469 Connecticut Health and Educational Facilities Authority, Capital City
1470 Economic Development Authority, **[**the**]** Health Information
1471 Technology Exchange of Connecticut, SustiNet Plan Authority and
1472 Connecticut Lottery Corporation and any person executing the bonds
1473 or notes of the agency shall not be liable personally on such bonds or
1474 notes or be subject to any personal liability or accountability by reason
1475 of the issuance thereof, nor shall any director or employee of the
1476 agency, including ad hoc members of the Connecticut Resources
1477 Recovery Authority, be personally liable for damage or injury, not
1478 wanton, reckless, wilful or malicious, caused in the performance of his
1479 or her duties and within the scope of his or her employment or
1480 appointment as such director, officer or employee, including ad hoc
1481 members of the Connecticut Resources Recovery Authority. The

1482 agency shall protect, save harmless and indemnify its directors,
1483 officers or employees, including ad hoc members of the Connecticut
1484 Resources Recovery Authority, from financial loss and expense,
1485 including legal fees and costs, if any, arising out of any claim, demand,
1486 suit or judgment by reason of alleged negligence or alleged
1487 deprivation of any person's civil rights or any other act or omission
1488 resulting in damage or injury, if the director, officer or employee,
1489 including ad hoc members of the Connecticut Resources Recovery
1490 Authority, is found to have been acting in the discharge of his or her
1491 duties or within the scope of his or her employment and such act or
1492 omission is found not to have been wanton, reckless, wilful or
1493 malicious.

1494 Sec. 25. Sections 19a-710 to 19a-723, inclusive, of the general statutes
1495 are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	17b-261(a)
Sec. 8	*from passage*	New section
Sec. 9	*from passage*	17b-90(b)
Sec. 10	*from passage*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	New section
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*from passage*	New section
Sec. 17	*from passage*	New section
Sec. 18	*from passage*	19a-750(c)(1)
Sec. 19	*from passage*	New section
Sec. 20	*from passage*	New section

Sec. 21	*from passage*	1-79(l)
Sec. 22	*from passage*	1-120
Sec. 23	*from passage*	1-124
Sec. 24	*from passage*	1-125
Sec. 25	*from passage*	Repealer section

Statement of Legislative Commissioners:

In section (5)(a)(8), "enter agreements" was changed to "enter into agreements" for clarity. In section 6(f)(2), "after conducted" was changed to "after conducting" for accuracy. In section 13(c), the two occurrences of "this section and section 6 of this act" were changed to "this section or section 6 of this act" for accuracy and the phrase "from every plan offered under the state employee plan" which previously appeared at the end of the sentence was inserted after the phrase "to offer coverage" for clarity. In section 13(d), the phrase "coverage for the state employee plan" was changed to "coverage under the state employee plan" for clarity. In sections 13(g)(2)(B) and 13(i)(2), "its finding" was changed to "such finding" for accuracy. In sections 13(m) and 15(k), the phrase "to the amount due" was added after "shall be added" for clarity. In section 15(f), "Comptroller" was changed to "authority" for accuracy and consistency with the rest of the subsection. In section 17(a), the phrase "Notwithstanding the provisions of this subsection, Medicaid, HUSKY Plan, Plan A and Part B, HUSKY Plus and Charter Oak Health Plan cost-sharing provisions shall be established by the authority" was changed to "Notwithstanding the provisions of this subsection, Medicaid, HUSKY Plan, Part A and Part B, HUSKY Plus and Charter Oak Health Plan cost-sharing provisions shall not be established by the authority" for accuracy.

PH	*Joint Favorable Subst. C/R*	INS
INS	*Joint Favorable C/R*	HS
HS	*Joint Favorable Subst.-LCO*	

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

OFA Fiscal Note

State Impact: See Below

Municipal Impact: See Below

Explanation

This bill creates a SustiNet Plan Authority, effective from passage. The Authority is a quasi-public entity charged in part with overseeing and implementing the provisions of the bill, including establishing the SustiNet Plan. The plan combines, between 2011 and 2014, multiple state funded health programs with municipal, non-profit, small employer and individual health insurance programs. It also expands state funded coverage under the Medicaid Low Income Adults (LIA) program and creates a new Basic Health Plan (BHP).

SustiNet Plan Authority: Oversight and Scope

The bill gives the Authority various powers to exercise as needed. The Authority's new administrative costs are estimated to be under $4 million in the first year and under $6 million annually thereafter, as the Authority develops its infrastructure.[1] The bill does not specify how the Authority is funded. These costs are associated with operating expenses, which include employing personnel (including an executive director), reimbursing board members for expenses incurred in performing their duties, obtaining surety bonds for board members (up to $50,000 per person), procuring stop-loss insurance, and hiring consultants. The Authority is also required to offer coverage under SustiNet G, which is discussed further below.

[1] Estimates are based on the costs of the Massachusetts Health Connector's first three years of operations and adjusted for the Sustinet Authority's specific scope and requirements. Costs associated with staffing do not include fringe benefits.

Existing Health Programs

Section 6 specifies that on or after January 1, 2012, the health programs overseen by the Department of Social Services (DSS) and the Office of the State Comptroller shall be known as the SustiNet Plans. The range of existing programs, current number of covered lives and the FY 12 estimated costs of these programs are as follows:

Current Program	Lives Covered	SustiNet Level	FY 12 Estimated Cost
Medicaid	560,977	A, D	$3,376,000,000
HUSKY B	14,840	B	$39,000,000
Charter Oak	8,834	C	$15,500,000
State Employees and Dependents	132,786	E	$644,600,000
State Retirees and Dependents	69,371	E	$597,400,000
TOTALS	**786,808**		**$4,672,500,000**

Under this provision, DSS and the Comptroller retain certain administrative controls over their respective programs. The bill allows the Authority to make program recommendations including changes to benefit and administrative program design. Any changes resulting from the adoption of the Authority's recommendations may impact the costs of serving these populations. The bill does not create a joint pool for these populations. Given the current size and the diversity of the two populations, it is uncertain whether additional economies of scale would result in savings if the populations were to be considered combined for the purposes of retaining an Administrative Service Organization to manage the benefits.[2]

SustiNet G

The bill requires the Authority to offer coverage, at the earliest feasible date on or after January 1, 2012, to a new group known as

[2] Congressional Research Service - The Market Structure of the Health Insurance Industry, November, 2009.

SustiNet G. SustiNet G would initially be open to employees and retirees: nonstate public employers, municipal-related employers, small employers and nonprofit employers, as defined by the bill. On or after January 1, 2014 SustiNet G would be opened to all individuals and employers in the state, including the uninsured. The bill does not require the state to provide the start-up capitalization funds required for SustiNet G and does not require any other funds from the state to support implementation. The bill specifies that SustiNet G is required to be funded by the premium payments charged to participants.[3] The following table provides information on the potential populations eligible to enroll in SustiNet G:

	Estimated Population
Non-State Public Employers (1)	577,949
Municipal-Related Employers(2)	Unavailable
Small Employers(3)	690,000
Nonprofit Employers(3)	174,342
Other Employers	Unavailable
Uninsured Individuals	380,500

Source: The Dept. of Labor and the Office of Healthcare Access
(1) Figures include dependents and retirees. (2) Information on this population is unavailable at this time. The bill defines these as employees of food service, property management, and school transportation businesses that contract with non-state public employers. (3) Figures do not include dependents or retirees, for which information is unknown.

The Authority will set the rates, benefits structure, cost-sharing and any other related provisions pertaining to SustiNet G. The table below provides a comparison of current average annual premium rates within various public and private sectors.

	Average Annual Premium Rates

[3] The bill establishes the Authority as the Insurer for SustiNet G. As such, it bears the risk of losses if the established premiums fail to cover the cost of claims. Should any Authority reserves be unable to pay for such losses, it is unclear who would bear the final loss. As the Authority is established as a quasi-public agency, the state of Connecticut could be liable to bear any loss.

	Employer	Single Coverage	Employee Share	Family Coverage	Employee Share
National*	Small Firms	$5,169	15%	$13,735	32%
	Large Firms	$5,104	19%	$14,161	25%
Regional*					
	Northeast	$5,252	19%	$14,117	24%
State⁺	State of Connecticut	$7,009	7%	$18,925	14%
	CT Cities & Towns	$8,000	10%	$21,300	10%
Local**	CT Boards of Education	$8,000	13%	$21,300	13%

**National and Regional PPO plan data obtained from 2010 Employer Health Benefit Survey. ⁺ State POE health plan data obtained from Office of the State Comptroller. ** Local data obtained from CT Public Sector Healthcare Cost & Benefit Survey 2009.*

For illustrative purposes, the Municipal Employer Health Insurance Plan (MEHIP) currently provides health insurance for groups that are similar to those served by SustiNet G. Annual premiums range from $3,300 to $10,956 for individual coverage and $23,232 to $45,564 for family coverage. Coverage for an uninsured individual not eligible for a public program or employer sponsored healthcare can range from $864 to $11,532 a year for individual coverage and $2,064 to $20,076 for individual plus one dependent coverage. The cost varies depending on the insurance provider and type of coverage purchased.

Nonstate Public Employers and the State Employee Health Plan

Sections 6 and 13 require the Comptroller on or after July 1, 2011, to offer coverage under the state employee and retiree health plan (hereafter referred to as "the Plan") to non-state public employers' employees and their retirees, contingent on the approval of the State Employee Bargaining Agent Coalition (SEBAC). Participation would be voluntary, with a two year minimum term. For those who enroll during the initial enrollment, coverage would start January 1, 2012.

Permitting additional participants to join the Plan could result in costs to the state and the Plan as a result of the following factors: 1) the impact to the existing pool, 2) actuarial costs, 3) additional staff, and 4)

loss of revenue.

Impact to the Existing Pool

The cost of the Plan is based on the demographics and claims experience of the existing pool. To the extent that additional lives affect the claims loss ratio, the cost of the state employee and retiree health plan would be directly impacted. The bill would allow the Comptroller to deny entry to the Plan for any partial group that was determined to adversely affect the risk of the current pool.

As of July 1, 2010, the Plan converted to a self-insured basis and now pays the total cost of claims on an incurred basis. Therefore, a monthly premium equivalent is estimated based on the anticipated annual claims. The Plan would incur a cost or savings to the extent that actual claims costs are more or less the premium equivalent being charged to employers.

The state spent approximately $1.1 billion in FY 10 on state employee and retiree health costs. Based on the FY 12 estimated requirements a 1% change in claims cost would equal approximately $12.4 million dollars; a 5% change in claims costs would equal approximately $62.1 million dollars. The Plan currently covers 202,157 lives.

It should be noted that the state does not currently have stop loss insurance or a reserve. Any additional costs may be mitigated by the fluctuating reserve fee that the Comptroller has the option to charge employers as explained below.

Actuarial Costs

The bill requires the Comptroller to permit enrollment for those employers who choose to enroll their entire workforce in the state employee plan. In the event the employer chooses to enroll only a portion of its workforce the Comptroller is required to forward the application to a health care actuary. It is assumed that the cost of actuarial services would be passed through to the employers; however

to the extent they are not fully charged to municipalities there may be a cost to the state. The Comptroller spent approximately $900,000 in FY 10 on actuarial services.

Additional Staff

The Comptroller may need two additional Retirement and Benefits Officers. The necessity of additional staff would depend on the degree to which non-state public employers chose to enroll their employees and retirees in the Plan. The annual salaries and fringe benefits associated with two additional positions is $185,117[4].

Loss of Revenue

Pursuant to CGS Sec. 12-202 municipalities and other non-state public employers currently offering health coverage through private health insurers are required to pay an Insurance Premium Tax to the state of 1.75% per contract or policy. [5] To the degree that this bill results in non-state public employers shifting their participation in fully-insured health plans to the state employee health plan, the state would experience a revenue loss from the Insurance Premiums Tax (policies written on behalf of the state and MEHIP are not subject to this tax). [6]

Impact on Nonstate Public Employers

There may be a cost or a savings to municipalities from joining the

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[4] The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated non-pension fringe benefit cost associated with personnel changes is 23.76% of payroll in FY 12 and FY 13. In addition, there could be an impact to potential liability for the applicable state pension funds.

[5] The state currently collects approximately $8 million a year from the premium tax on health insurance policies procured by municipalities.

[6] Current law exempts new or renewed contracts or policies written to provide coverage to municipal employees under a plan procured pursuant to CGS 5-259(i) from the premiums tax. Therefore, MEHIP participants are currently exempt from the premiums tax. As a result, there would not be a loss to the premiums tax should MEHIP participating non-state public employers shift coverage to the state employee health plan.

plan. Municipalities may incur additional expenses if the cost of joining the Plan is greater than the cost the municipality currently pays for healthcare coverage. Potential costs or savings would be related to: 1) premiums, 2) administrative fees, and 3) fluctuating reserve fees. It is unlikely that any municipalities, whose current premiums and administrative costs are lower than the premiums of the Plan, would choose to join.

Premiums

It is estimated that approximately 578,000 employees, dependents and retirees would be eligible to join the Plan. Employers would be required to pay the same base premium rates as the state. However, it would be up to the employer to determine cost sharing provisions with employees, pursuant to their current practice.

Currently under the Plan, total annual premiums range from $5,320 to $9,928 for individual coverage and $14,364 to $26,807 for family coverage. Municipal employers in the state, on average, cover approximately 90% of the premium for individual coverage and 87% for family coverage.[7] Under the state employee plan this would equate an employer's cost of $4,788 to $8,935 for each employee enrolled in an individual plan, and $12,497 to $23,322 for each employee enrolled in a family plan. The bill does not require the Comptroller to offer all of the plan options to non-state public employers. The premium related costs to municipalities would depend on the plan selected, the percentage of premiums the employer pays on the employee's behalf and the number of individuals enrolled. For employers who choose to enroll in the Plan, there would be a cost to municipalities if the cost of premiums is more than what they are currently paying and a savings if the cost were less.

Fees

The bill allows to Comptroller to charge participating employers a

[7] *CT Public Sector Healthcare Cost & Benefit Survey*, 2009.

per member per month administrative fee and a fluctuating reserve fee in addition to premiums. The amount of the administrative fee would be determined by the Comptroller. In addition, the Comptroller may charge a fluctuating reserves fee in an amount necessary to ensure adequate claims reserves. It is common practice to establish a reserve consisting of approximately two months' worth of anticipated claims costs. These reserve costs could range from approximately $85-$313 per member per month.

There may be savings to municipalities if the amount they are currently paying per employee for premiums or claims costs and for administrative costs is more than what they would pay under the plan. Fully insured municipalities who currently offer health coverage through a private health insurer will save from not having to pay the Insurance Premiums Tax. The current amount municipalities pay for administrative and other health care costs has not been determined.

Mandates

Section 11(c)(4) requires the SustiNet Plan be subject to the health insurance mandates in chapter 700c of the general statutes. The state employee health plan is self insured and therefore under federal law is exempt from current state health mandates, but may adopt them voluntarily. As of January 1, 2012 the bill includes the state employee and retiree health plan as part of the SustiNet Plan. Therefore to the extent that the state employee health plan adopted all mandates required by the bill there may be a cost to the state for mandates which are not currently covered. The cost would depend on the type of coverage mandated and utilization.[8]

The state employee health plan is recognized as a "grandfathered" health plan under the Patient Protection and Affordable Care Act (PPACA). It is unclear what effect the adoption of certain health

[8]As of January 1, 2009 there were 45 health insurance mandates required by the state. The mandated benefits in effect as of January 1, 2009 accounted for approximately 22% of total premiums for group coverage. (Source: *Connecticut Mandated Health Insurance Benefits Review*, 2010).

mandates will have on the grandfathered status of the state employee health plan under PPACA. [9] If the state were to lose its grandfathered status it may be subject to certain coverage requirements without cost-sharing and other patient protections as required by PPACA.

Implications for Collectively Bargained Benefits

Sections 16 & 17 of the bill specify the state employee and retiree health plan shall be administered by the Comptroller. However, the Authority is charged with establishing the rules for the plan, including cost-sharing requirements. No change to cost sharing requirements for state employees or retirees shall be effective without the approval of SEBAC.

The bill effectively replaces the State with the Authority in matters pertaining to state employee and retiree health benefits. In FY 11, state employee and retiree health costs comprise approximately 20% of personnel costs, or approximately $1.1 billion dollars. The cost or savings to the state would depend on the cost sharing and other plan changes recommended by the Authority, and adopted by SEBAC.

In addition, the State Employee Retirement System (SERS) and all employee and retiree health plans are provided in accordance with the collective bargaining agreement negotiated between the State and SEBAC. CGS Sec. 5-278 (f) recognizes SEBAC to negotiate with the State on retirement and health benefits. In 1997 the State and SEBAC negotiated a long-term health and retirement benefit agreement, which is effective through 2017. This agreement was most recently modified in 2009. Therefore, any additional plan changes suggested by the Authority would not be effective until 2017 or until the contract is

[9] According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www. healthcare.gov)

amended.

Lastly, as previously stated, the state employee health plan is recognized as a grandfathered health plan under PPACA. It is unclear what effect cost sharing changes will have on the grandfathered status of the plan under PPACA.

SustiNet Account

Section 12 establishes a non-lapsing SustiNet account. The account shall contain all SustiNet Plan premiums, received under sections 13 and 15 of the bill, and all public or private funds provided to the SustiNet Plan Authority. The bill allows the Comptroller to make expenditures from the account at the direction of the SustiNet Plan executive director.

Medicaid for Low Income Adults

Section 7 of the bill expands the Medicaid LIA coverage group, effective January 1, 2014. Currently, childless adults are covered under this group with incomes up to approximately 68% of the federal poverty level (FPL). This bill raises this income limit to 133% FPL, as required by PPACA. PPACA requires states to submit an amendment to the state Medicaid plan to implement this expansion. As the bill is codifying an existing federal mandate, there is no direct fiscal impact from this language. [10]

Basic Health Plan

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10 It is estimated that by 2014, there will be approximately 81,000 enrollees in the existing LIA coverage group, at a cost of $728 million annually. Based on this enrollment pattern, the expansion to 133% FPL would add an additional 32,000 clients, with annual costs of $288 million.

Under PPACA, the cost of the expansion of coverage to childless adults is fully covered by the federal government until January 1, 2017. Therefore, there is no cost to the state for this expansion until that date. After January 1, 2017, the federal government's share gradually declines from 100% to 90% by 2020. Therefore, the state's cost for this expansion grows from $8.9 million in FY 17 to $32.8 million in FY 20.

Section 7 of the bill also requires DSS to implement, on or after January 1, 2014, the Basic Health Plan option in accordance with PPACA. This requirement will result in a net additional annual state cost of between $222.8 million and $478.6 million, and will cover an estimated 85,250 new individuals. Details on the various parts involved in this estimate appear below.

This proposal would create a new state program, outside the federally mandated insurance exchanges, for adults with incomes between 133% FPL and 200% FPL. This section specifically moves parents within this income band who are current enrollees in the HUSKY A program to the new BHP. The section specifies that all benefits, cost sharing requirements and consumer safeguards in place for the Medicaid program shall apply to the BHP.

The fiscal impact to the state from these provisions would be twofold. First, the state will realize a savings under the HUSKY program as parents with incomes in excess of 133% FPL are disenrolled. It is estimated that there will be 16,000 parents in this category by 2014, with an annual cost per case of $6,000. [11] Therefore, the state would realize net annualized savings of $48 million (after 50% federal reimbursement).

The new BHP program is expected to serve 101,250 clients when fully annualized. [12] Although the costs of the clients transferred from HUSKY are anticipated to be consistent, it is not known what the cost

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[11] Although the current cost per case for the overall HUSKY A population is $3,333 (including carve outs), the population is two-thirds children. According to the Insurance Department, the cost of covering adults is approximately 2 and 1/2 times the cost of covering a child. Controlling for the HUSKY A child population, and assuming 5% annual inflation until 2014, results in an estimated per person cost for HUSKY A adults of $6,000.

[12] This assumes 16,000 former HUSKY A parents and 82,500 non-HUSKY adults. According to Connecticut Department of Revenue Services data, there were 225,000 tax filers with incomes between $14,000 and $22,000 in 2009. The U.S. Census Bureau estimates that 29% of individuals with incomes under $25,000 are uninsured. This would yield approximately 65,250 individuals. It is further assumed that about 7% of those in this income bracket who currently have insurance would drop that to enroll in the BHP, for a total of 82,500 non-HUSKY BHP enrollees.

profile of the new, non-HUSKY enrollees will be. As the BHP is required to have the same benefits and cost sharing as the Medicaid program, it may be assumed that the cost per case for this new program will be roughly equivalent to the current HUSKY program costs for adults, or approximately $6,000 by 2014. Therefore, the gross annualized program cost is anticipated to be $607.5 million. Should the cost profile of the non-HUSKY BHP enrollees be similar to that of the LIA population ($9,000 annually) the gross annualized program cost would be $863.3 million.

Under PPACA, the state will receive a federal subsidy for those residents enrolled in the BHP. This subsidy is equal to 95% of what the federal government would have spent on premium tax credits and cost sharing reductions that BHP enrolled individuals would have been eligible for had they purchased private insurance through the State Insurance Exchange. The tax credits and cost sharing reductions are based on the "Silver Plan" on the insurance exchange. At this time, the federal government has not stated what the essential benefit package will be, which will dictate both the cost of the Silver Plan and the value of the associated federal subsidy.

For the purposes of this analysis, the cost of the Silver Plan is estimated to be $4,500 annually.[13] Based on maximum client contributions included in PPACA, it is estimated that the federal subsidy available for the BHP will be $3,325 annually.[14] Compared to the $6,000 to $9,000 estimated cost for the BHP, there exists $2,675 to

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[13] Although the cost of the Silver Plan has not been established, the Congressional Research Service and Congressional Budget Office have used $4,500 as a general estimate. The final average cost of the Silver plan will be dependent upon the benefit plan as well as the age of the individuals enrolled.

[14] PPACA includes maximum client premium and cost sharing for Exchange products, which vary by income limit. Based on these requirements, this analysis assumes that a client's share of the premium would average $1,000 (derived from Kaiser Family Foundation estimates). The federal subsidy available for the BHP would be 95% of the federal share of the cost of the Silver Plan. Therefore, the federal subsidy would be $3,325, which equates to ($4,500 - $1,000)*95%. It should be noted that PPACA indexes the federal subsidy to the Consumer Price Index (CPI). If the average cost of the Silver plan increases at a higher rate than the CPI, the real value of the subsidy will decrease over time.

$5,675 annual cost per person that is not covered by the federal subsidy. Given the bill's requirement that the BHP have the same cost sharing as the state Medicaid program (which is currently $0), it is assumed that the state must pay the unsubsidized costs for all BHP enrollees. Based on the enrollment and cost assumptions above, the new BHP benefit for all clients would result in a net state cost of between $270.8 million and $526.6 million annually.

Basic Health Plan – HUSKY A Impact

	Clients	State Cost per year	Impact
Remove clients from HUSKY A	-16,000	$3,000	-$48,000,000
Enroll HUSKY A Clients in BHP	16,000	$2,675	$42,800,000
Net Savings			**-$5,200,000**

Basic Health Plan - Non-HUSKY Impact

	State Cost – HUSKY Level	State Cost – LIA Level
Plan Cost	$6,000	$9,000
Cost less Federal Subsidy	$2,675	$5,675
Clients	85,250	85,250
Net State Cost	**$228,043,750**	**$483,793,750**
Cost Less HUSKY A Savings	**$222,843,750**	**$478,593,750**

Basic Health Plan Account

Section 8 creates a non-lapsing basic health program account from which the costs to operate the BHP are to be paid by the SustiNet Plan Authority. It is assumed that the federal BHP subsidy would be deposited in this account. However, it is not clear what the source of funds for the state cost for the unsubsidized portion of the BHP benefit

identified above. Presumably, a General Fund appropriation would have to be made.

SustiNet Policies to Slow Growth

Section 11 of the bill requires the SustiNet Plan to be administered to slow the growth of health care costs. Although not mandated, the bill encourages several health delivery and administrative methods intended to reduce costs. It is expected that by 2014, the SustiNet Plan will be administering between $5.60 billion and $5.85 billion in health care costs among the mandatory populations (including the LIA and BHP expansions).[15] Therefore, any 1% change in health care costs that result from the Plan's strategies would result in a change in expenditures of between $56 million and $58.5 million. Given the potential for a much larger pool through the addition of the optional SustiNet G populations, these figures could increase.

Authority to Cover Uninsured

Section 11 of the bill also requires the Authority to develop and implement policies to retain coverage for otherwise uninsured individuals. The bill specifies that this provision is to be implemented within available appropriations.

According to the Office of Health Care Access, in 2009 there were approximately 380,500 uninsured individuals in Connecticut. However, implementation of the insurance Exchange, recent changes in LIA, including the expansion of LIA and the creation of the BHP elsewhere in this bill, are likely to significantly reduce this figure.

The methods, and associated costs, by which the Authority may seek to provide coverage for the uninsured are not known. However, should these methods result in additional clients enrolling in state subsidized health care, including Medicaid, HUSKY, Charter Oak, the Basic Health Plan and the State Employee Plan, additional state costs

[15] Includes current DSS and state employees ($4.7 billion), LIA expansion ($288 million) and the BHP ($607.5 million to 863.8 million)

would result.

Convener Authority

Section 20 gives the Comptroller power to act as a convener authority for health care institutions, facilities and providers in the state.

The Out Years

The relevant out year impacts from this bill are included in the analysis above. Many of the proposals in the bill are closely tied to federal reform efforts, and are likely to be affected by regulations and changes that are still forthcoming from the federal government.

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, emphaze 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)