

**PA 09-148—sHB 6600 (VETOED) (OVERRIDDEN)**

*Public Health Committee*

*Human Services Committee*

*Labor and Public Employees Committee*

*Insurance and Real Estate Committee*

**AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN**

**SUMMARY:** This act establishes a nine-member SustiNet Health Partnership board of directors that must make legislative recommendations, by January 1, 2011, on the details and implementation of the “SustiNet Plan,” a self-insured health care delivery plan. The act specifies that these recommendations must 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 (“medical homes”), 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 development of a model benefits package; and
4. public outreach and methods of identifying uninsured citizens.

The board must 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 establishes an independent information clearinghouse to provide employers, consumers, and the general public with information about SustiNet and private health care plans.

Finally, the act creates task forces addressing obesity, tobacco usage, and the health care workforce.

**EFFECTIVE DATE:** July 1, 2009, except that the sections on identifying uninsured adults and children (§§ 14 and 15) and Medicaid and public education outreach (§ 13) take effect July 1, 2011, and the three task forces (§§ 16-18) take effect upon passage.

**§ 1 — DEFINITIONS**

The act defines the “SustiNet Plan” as a self-insured health care delivery plan designed to ensure that its enrollees receive high-quality health care coverage without unnecessary costs. “Public authority” means a public authority or other entity recommended by the SustiNet Health Partnership board of directors.

“Standard benefits package” means a set of covered benefits, as determined by the public authority, with out-of-pocket cost-sharing limits and provider network rules, subject to the same coverage and utilization review mandates that apply to small group health insurance sold in the state. It includes, but is not limited to:

1. coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical, and occupational therapy; home health care; vision care; family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; identification and treatment of developmental delays from birth through age three; and evidence-based wellness programs;
2. a per-individual and per-family deductible that excludes drugs and preventive care;

3. preventive care with no copayment;
  4. prescription drug coverage, with copayments;
  5. office visits for other than preventive care, with copayments;
  6. mental and behavioral health services coverage, including tobacco cessation, substance abuse treatment, and obesity prevention and treatment (these services must have parity with coverage for physical health services); and
  7. dental coverage comparable to that provided by large employers in the Northeast.
- A “small employer” is a person, firm, corporation, limited liability company, partnership, or association actively engaged in business or self-employed for at least three consecutive months, which, on at least 50% of its working days during the preceding 12 months, employed up to 50 people, the majority of whom worked in the state.

## § 2 — THE SUSTINET HEALTH PARTNERSHIP BOARD OF DIRECTORS

### *Board Members*

The act establishes the Sustinet Health Partnership board of directors consisting of nine members as follows:

1. the state comptroller;
2. the healthcare advocate;
3. a representative of the nursing or allied health professions, appointed by the governor;
4. a primary care physician, appointed by the Senate president pro tempore;
5. a representative of organized labor, appointed by the House speaker;
6. an individual with expertise in providing employee health benefit plans for small businesses, appointed by the Senate majority leader;
7. an individual with expertise in health economics or policy, appointed by the House majority leader;
8. an individual with expertise in health information technology, appointed by the Senate minority leader; and
9. an individual with expertise in actuarial sciences or insurance underwriting, appointed by the House minority leader.

The comptroller and healthcare advocate serve as board chairpersons.

Initial appointments must be made by July 15, 2009. If an appointing authority fails to appoint a member by July 31, 2009, the Senate president pro tempore and the House speaker jointly make that appointment. A quorum is five members.

Board members' terms are staggered. The initial term for the governor's appointee is two years. For those appointed by the House and Senate majority leaders, the term is four years. For the House and Senate minority leaders' appointments, the term is three years. And the term is five years for the appointments of the House speaker and Senate president pro tempore. After the initial term, board members serve five-year terms.

Within the 30 days before a term expires, the appointing authority can reappoint a current member or appoint a new one. Board members can be removed by their appointing authority for misfeasance, malfeasance, or willful neglect of duty.

The act specifies that any individual serving on the board is subject to existing law on filing a statement of financial interests.

It specifies that the board is not a state department, institution, or agency.

## § 3 — DUTIES OF THE SUSTINET BOARD OF DIRECTORS

### *Designing the Sustinet Plan*

The Sustinet Health Partnership board of directors must design and establish procedures to implement the “Sustinet Plan,” which must be designed to:

1. improve the health of state residents;
2. improve the quality of health care and access to health care;
3. provide health insurance coverage to Connecticut residents who would otherwise be uninsured;
4. increase the range of health care insurance coverage options available to residents and employers;
5. slow the short- and long-term growth of per capita health care spending; and
6. implement reforms to the health care delivery system that will apply to all Sustinet Plan members. But any reforms to health care coverage provided to state employees, retirees, and their dependents must be subject to applicable collective bargaining agreements.

By January 1, 2011, the board must submit its design and implementation procedures in recommended legislation to the Appropriations and the Finance, Revenue and Bonding committees.

#### *Designing the Public Authority*

The board must offer recommendations to the General Assembly on the governance structure of the entity that is best suited to oversee and implement the Sustinet Plan. These recommendations may include, but are not limited to, the establishment of a public authority authorized to:

1. adopt guidelines, policies, and regulations necessary to implement the act's provisions related to Sustinet;
2. contract with insurers or other entities for administrative purposes, such as claims processing and provider credentialing, taking into account their capacity and willingness to (a) offer networks of participating providers both within and outside the state and (b) help finance the administrative costs involved in the establishment and initial operation of the Sustinet Plan, and reimbursing them using per capita fees or other methods that do not create incentives to deny care;
3. solicit bids from individual providers and provider organizations to provide all Sustinet Plan members with timely access to high-quality care throughout the state and, in appropriate cases, outside the state;
4. establish appropriate deductibles, standard benefit packages, and out-of-pocket cost-sharing levels for different providers that may vary based on quality, cost, provider agreement to refrain from balance billing Sustinet Plan members, and other factors relevant to patient care and financial sustainability;
5. commission surveys of consumers, employers, and providers on issues related to health care and health care coverage;
6. negotiate on behalf of Sustinet Plan providers to obtain discounted prices for vaccines and other health care goods and services;
7. contract for such professional services as financial and other consultants, actuaries, bond counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, bio-ethicists, and others as the board deems necessary;
8. purchase reinsurance or stop-loss coverage, set aside reserves, or take other prudent steps to avoid excess exposure to risk in administering a self-insured plan;

9. enter into interagency agreements for performance of Sustinet Plan duties that may be implemented more efficiently or effectively by a state agency;
10. set payment methods for licensed health care providers that reflect evolving research and experience both within the state and elsewhere, promote patient health, prevent unnecessary spending, and ensure sufficient compensation to cover the reasonable cost of furnishing necessary care;
11. appoint advisory committees to successfully implement the Sustinet Plan, further the objectives of the authority, and secure necessary input from various experts and stakeholder groups;
12. establish and maintain an Internet web site that provides for timely posting of all public notices issued by the authority or the board and such other information either deems relevant in educating the public about the Sustinet Plan;
13. evaluate the implementation of an individual mandate together with guaranteed issue, elimination of preexisting condition exclusions, and the implementation of auto-enrollment;
14. raise funds from public and private sources outside of the state budget to contribute toward support of its mission and operations;
15. make optimum use of opportunities created by the federal government for securing new and increased federal funding, including increased reimbursement revenues;
16. if the federal government enacts national health care reform, submit preliminary recommendations for implementing the Sustinet Plan to the General Assembly, not later than 60 days after federal enactment; and
17. study the feasibility of funding premium subsidies for individuals with incomes between 300% and 400% of the federal poverty level (FPL).

The act specifies that all state and municipal agencies, departments, boards, commissions, and councils must fully cooperate with the board in carrying out these purposes.

#### § 4 — SUSTINET PLAN

The board of directors must develop the procedures and guidelines for the Sustinet Plan, which must comport with these Institute of Medicine (IOM) principles:

1. health care coverage should be universal, continuous, and affordable to individuals and families;
2. the health insurance strategy should be affordable and sustainable for society; and
3. health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

The board must identify all potential funding sources that may be used to establish and administer the Sustinet Plan. It must recommend that the public authority establish action plans with measurable objectives in such areas as:

1. effective management of chronic illness,
2. preventive care,
3. reducing racial and ethnic disparities in health care and health outcomes, and
4. reducing the number of uninsured state residents.

The board must include recommendations that the authority monitor the progress made toward achieving these objectives and modify the action plans as necessary.

#### §§ 1 & 5 — HEALTH INFORMATION TECHNOLOGY

The act delineates how electronic health records will be established for Sustinet members and how participating providers may gain access to hardware and approved software for interoperable electronic medical records. For these purposes, the act defines:

1. "electronic medical record" as a record of a person's medical treatment created by a licensed health care provider and stored in an interoperable and accessible digital format;
2. "electronic health record" as an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across multiple health care organizations;
3. "subscribing provider" as a licensed health care provider that (a) either is a participating provider in the Sustinet plan or provides services in the state and (b) agrees to pay a proportionate share of the cost of health care technology goods and services, consistent with board-adopted guidelines; and
4. "approved software" as electronic medical records software approved by the board after receiving recommendations from the information technology committee the act establishes.

#### *Information Technology Committee and Plan Development*

The board must establish an information technology committee to make a plan for developing, acquiring, financing, leasing, or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers. The plan must include the development of a periodic payment system that allows these providers to acquire approved software and hardware and receive other support services for implementing electronic medical records.

#### *Software and Hardware Options and Availability*

The committee must make recommendations on (1) providing approved software to subscribing providers and participating providers (the act does not define this term), consistent with the act's capital acquisition, technical support, reduced-cost digitization of existing records, and software updating and transition procedures and (2) developing and implementing procedures to ensure that individual providers and hospitals have access to hardware and approved software for interoperable electronic medical records and establishment of electronic health records for Sustinet Plan members.

The information technology committee must consult with technology specialists, physicians, nurses, hospitals, and other health care providers to identify potential software and hardware options that meet the needs of all types of health care practices.

Any electronic medical records package the committee recommends for possible purchase must interact with other pertinent modules, including practice management, patient scheduling, claims submission, billing, and tracking of laboratory orders and prescriptions.

A package must also include:

1. automated patient reminders concerning upcoming appointments;
2. recommended preventive care reminders;
3. automated provision of test results to patients when appropriate;
4. decision support, including notice of recommended services not yet received by a patient;
5. notice of potentially duplicative tests and other services;

6. notice of potential drug interactions and past adverse drug reactions to similar medications;

7. notice of possible violation of patient wishes for end-of-life care; and

8. notice of services provided inconsistently with care guidelines.

The committee must make recommendations on procuring and developing approved software. These recommendations may include that any approved software be able to gather information to help the board assess health outcomes and track the accomplishment of clinical care objectives. The board must ensure that Sustinet Plan providers who use approved software can electronically transmit to, and receive information from, all laboratories and pharmacies participating in the plan, without the need to construct interfaces other than those constructed by the authority.

The committee must make recommendations on selection of public vendors to provide reduced-cost, high-quality digitization of paper medical records for use with approved software. The vendors must be bonded, supervised, and covered entities under the federal Health Insurance Portability and Accountability Act, that is, subject to the act's privacy requirements.

#### *System Integration*

The information technology committee must make recommendations on a system for integrating information from subscribing providers' electronic medical records systems into a single electronic health record for each Sustinet Plan member. This integrated record must be updated in real time and accessible to any participating or subscribing provider serving the member.

The act requires all recommendations on electronic health and medical records to be developed in a manner consistent with board-approved guidelines for safeguarding privacy and data security and with state and federal laws, including any recommendations of the U. S. Government Accountability Office. These guidelines must include recommended remedies and sanctions in cases where guidelines are not followed. The remedies can include termination from the network or reimbursement denial or reduction.

The committee must recommend methods to coordinate the development and implementation of electronic medical health records in concert with the Department of Public Health (DPH) and other state agencies to ensure efficiency and compatibility. It must determine appropriate financing options, including financing through the Connecticut Health and Educational Facilities Authority.

#### *Condition of Participation in Sustinet*

Under the act, the committee must recommend that use of board-approved or compatible electronic medical records become a condition of provider participation in the Sustinet plan by July 1, 2015, with possible time extensions or exemptions made for providers who would face hardship in meeting the deadline and whose participation in Sustinet is necessary to assure geographic access to care. It authorizes the board to provide additional support to these providers. (But it is not clear what kind of support the board can provide. )

The act includes specific incentives to help providers meet the goal of adopting electronic medical records by July 1, 2015. The committee must recommend the development and implementation of appropriate financial incentives for early subscriptions by participating providers, including discounted fees.

The committee must develop recommended methods to eliminate or minimize transition costs for providers, who, before January 1, 2011, implemented comprehensive electronic medical or health records systems. These can include technical assistance in transitioning to new software and development of modules to help existing software connect to the integrated system.

The committee must make recommendations that subscribing providers share systemic cost savings achieved by implementing electronic medical and health records. The amount of savings the board shares with a provider is limited to the amount of net financial loss the provider experienced during the first five years of the implementation process using board-approved software. But a provider that lost money because it failed to use the authority's technical support and services cannot share in any cost savings.

The committee must also make recommendations on the use of electronic health records to encourage the provision of medical home functions (see below). Electronic health records must generate automatic notices to medical homes that (1) report when an enrolled member receives services outside the medical home, (2) describe member compliance or noncompliance with provider instructions, and (3) identify the expiration of refillable prescriptions.

## § 6 — MEDICAL HOMES

### *Medical Home Advisory Committee*

The board must establish a medical home advisory committee composed of physicians, nurses, consumer representatives, and other qualified individuals chosen by the board. The committee must develop recommended internal procedures and proposed regulations for the administration of medical homes serving SustiNet Plan members. The committee must forward its recommendations to the board.

### *Medical Home Functions*

Committee recommendations must include that (1) the board define medical home functions on an ongoing basis, incorporating evolving research on delivery of health care services and (2) if provider infrastructure limits prevent all SustiNet Plan members from enrolling in a medical home, then enrollment be implemented in phases with priority given to members where cost savings appear most likely, including members with chronic health conditions.

The committee, subject to revision by the board, must make recommendations that initial medical home functions include the following:

1. assisting members to safeguard and improve their own health by:
  - a. advising members with chronic health conditions on how to monitor and manage their conditions;
  - b. working with members to set and accomplish goals related to exercise, nutrition, and tobacco use, among other behaviors;
  - c. implementing best practices to ensure members understand and can follow medical instructions; and
  - d. providing translation services and culturally competent communication strategies;
2. care coordination that includes:
  - a. managing transitions between home and hospital;
  - b. monitoring to ensure members receive all recommended primary and preventive care services;

- c. providing basic mental health care, including screening for depression, with referral for those who require more help;
  - d. addressing workplace, home, school, and community stress;
  - e. referring to nonmedical services such as housing, nutrition, domestic violence programs, and support groups; and
  - f. ensuring information about members with complex health conditions is shared among multiple providers and that the providers follow a single integrated treatment plan; and
3. providing 24-hour access by telephone, secure email, or quickly scheduled office appointments in order to reduce the need for hospital emergency room visits.

The committee may develop quality and safety standards for medical home functions that are not covered by existing professional standards. These may include care coordination and member education.

The committee must recommend to the board that the public authority assist in developing community-based resources to enhance medical home functions, including:

1. making loans available on favorable terms to help develop necessary health care infrastructure, including community-based providers of medical home and preventive care services;
2. offering reduced-price consultants to help providers restructure their practices and offices to function more effectively and efficiently in response to changes in health care insurance coverage and service delivery attributable to Sustinet implementation; and
3. offering continuing medical education courses for physicians, nurses, and other clinicians, including training in culturally competent delivery of health care services.

#### *Health Care Providers Who Can Serve as Medical Homes*

The committee must make recommendations on entities that can be a medical home. These include that (1) a licensed health care provider who is authorized to provide all core medical home functions prescribed by the board can serve as a medical home and (2) a group practice or community health center serving as a medical home must identify, for each member, a lead provider with primary responsibility for the member's care. In appropriate cases, as determined by the board, (1) a specialist may serve as a medical home and (2) a patient's medical home may temporarily be with a health care provider who is overseeing the patient's care for the duration of a temporary medical condition, including pregnancy.

The committee must make recommendations on the medical home provider's responsibilities. These include that (1) each medical home provider be given a list of all medical home functions and (2) if a provider does not wish to perform certain non-core medical home functions in his or her office, the provider must arrange for other qualified entities or individuals to perform these functions in a way that integrates them into the medical home's clinical practice.

These other entities or individuals must be certified by the board based on the quality, safety, and efficiency of the service they provide. At the medical home provider's request, the board must make all arrangements required for a qualified entity or individual to perform any medical home function (not just non-core functions) the core provider does not assume.

#### *Reimbursement*

The committee must make recommendations concerning payment for medical home functions. These must include that (1) all medical home functions are reimbursable under

the Sustinet Plan; (2) in setting payment levels for those functions that are not normally reimbursed by commercial insurers, payment cover the full cost of services; and (3) rate-setting mechanisms can include using Medicare rate-setting methods or a monthly case management fee.

The committee must make recommendations that specialty referrals include prior consultation between the specialist and the medical home to determine whether the referral is medically necessary. If so, the consultation must identify any tests or procedures that must be done or arranged by the medical home before the specialty visit to promote economic efficiencies. The act requires the Sustinet Plan to reimburse the medical home and specialist for time spent on consultations.

#### § 7 — HEALTH CARE PROVIDER COMMITTEE; CLINICAL CARE AND SAFETY GUIDELINES

The act requires the board to establish a health care provider committee to develop clinical care and safety guidelines for use by Sustinet providers. The committee must choose from existing nationally and internationally recognized care guidelines. It must continually assess the quality of evidence, the relevant costs, and the risks and benefits of treatments. It must forward its recommendations to the board. The committee must have provider and consumer members.

Under the act, the committee must recommend that participating Sustinet providers receive confidential reports comparing their practice patterns with their peers. These reports must include opportunities for continuing education.

The committee must make recommendations on quality of care standards for particular medical conditions. Such standards may reflect outcomes over the entire care cycle for each health care condition, adjusted for patient risk and general consistency of care with approved guidelines and other factors. The committee must recommend that providers who meet or exceed the standards for a particular condition be publicly recognized and made known to Sustinet members, including those who have been diagnosed with that particular medical condition.

The committee must recommend procedures requiring hospitals and their staffs, physicians, nurse practitioners, and other participating providers to periodically conduct quality of care reviews and develop quality of care improvement plans. Such reviews must identify potential problems manifesting as adverse events or events that could have resulted in negative patient outcomes. As appropriate, they must incorporate confidential consultation with peers and colleagues, opportunities for continuing medical education, and other interventions and supports to improve performance. To the maximum extent permissible, the reviews must incorporate existing peer review mechanisms. The committee's recommendations must include that any review conducted be subject to the law's protections concerning peer review (CGS § 19a-17b).

The board, in consultation with the committee, must develop safety standards for implementation in hospitals. The board must establish procedures to monitor and impose sanctions to ensure compliance with the standards. It may also establish performance incentives to encourage hospitals to exceed the standards.

The committee must make recommendations on providing participating providers with information about prescription drugs, medical devices, and other goods and services. This information can address emerging trends involving the use of goods and services that the authority judges are less than optimally cost effective. The committee must make

recommendations on providing free samples of generic or other prescription drugs to participating providers. And the committee must recommend policies and procedures to encourage participating providers to furnish Sustinet members with appropriate evidence-based health care.

#### § 8 — PREVENTIVE HEALTH CARE AND COMMUNITY-BASED PREVENTIVE HEALTH INFRASTRUCTURE

The act requires the board of directors to establish a preventive health care committee that uses evolving medical research to make recommendations to improve health outcomes for members (presumably Sustinet members) in areas involving nutrition, physical exercise, sleep, and the prevention and cessation of use of tobacco and other addictive substances, taking into account programs already underway in the state. The committee must include providers, consumers, and others chosen by the board. These recommendations may be targeted to special member populations that are most likely to benefit from them. They can include behavioral components and financial incentives for participants. Beginning July 1, 2010, the committee must annually submit its recommendations to the board.

The board must recommend that the Sustinet plans sold to employers or individuals cover community-based preventive care services that can be administered safely in community settings. These services must include immunizations, simple tests, and health care screenings, and the board must recommend that they be provided in workplaces, schools, or other community locations. The board must recommend that community-based preventive care providers must (1) use the patient's electronic health record to confirm that a service has not been provided before and is not contraindicated and (2) furnish test results or documentation of the service to the patient's medical home or primary care provider.

#### § 9 — ENROLLMENT OF VARIOUS GROUPS IN SUSTINET

##### *Nonstate Public Employers; State Employees, Retirees and Dependents; Nonprofits; and Small Businesses*

The board may develop recommendations that ensure that, beginning July 1, 2012, nonstate public employers and employees of nonprofit organizations and small businesses are offered the benefits of the Sustinet Plan. The act defines “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 board may develop recommendations that permit the comptroller to offer the Sustinet Plan benefits to state employees, retirees, and their dependents (the act does not specify a date for doing this). No changes in state employee health care plan benefits can be implemented unless they are negotiated and agreed to by the state and the State Employee Bargaining Agent Coalition committee (SEBAC) through the collective bargaining process.

##### *HUSKY PLAN Part A and B Beneficiaries*

The board must develop recommendations to ensure that the HUSKY Plan Part A and Part B, Medicaid, and State-Administered General Assistance (SAGA) programs participate in the Sustinet Plan. These recommendations must also ensure that HUSKY Plan Part A or B benefits are extended, to the extent permitted by federal law, to adults with income up to 300% of FPL.

##### *Those Not Offered Employer-Sponsored Insurance*

The act requires the board to make recommendations to ensure that state residents not offered employer-sponsored insurance (ESI) and who do not qualify for HUSKY Part A or B, Medicaid, or SAGA can enroll in Sustinet beginning July 1, 2012. These recommendations must ensure that premium variation based on member characteristics does not exceed, in total amount or in consideration of individual health risk, the variation state law permits for a small employer carrier.

*Those Offered Unaffordable or Inadequate ESI*

The board must make recommendations to provide an option for enrollment in Sustinet to state residents whose household income is 400% of FPL or less who are offered ESI. The board may make recommendations for establishing (1) a procedure for those eligible individuals to enroll in Sustinet and (2) a way to collect payments from employers whose employees would have received ESI, but instead enroll in Sustinet.

§ 10 — OFFERING SUSTINET TO EMPLOYERS THROUGH EXISTING CHANNELS

The act requires the board to make recommendations concerning:

1. use of various ways to sell Sustinet to employers, including public and private purchasing pools, agents, and brokers;
2. offering employers multi-year contracts that have predictable premiums;
3. policies and procedures to ensure that employers can easily and conveniently purchase Sustinet plan coverage for their workers and dependents, including participation requirements, timing of enrollment, open enrollment, enrollment length, and other matters the board deems appropriate;
4. policies and procedures to prevent adverse selection; (“adverse selection,” in this context, means purchase of Sustinet Plan coverage by employers with unusually high-cost employees and dependents under circumstances where premium payments do not fully cover the employer’s probable claims costs);
5. availability of Sustinet Plan coverage for small employers on and after July 1, 2012 with premiums based on member characteristics as permitted for small employer carriers;
6. availability of Sustinet plan coverage for larger employers with premiums to prevent adverse selection, taking into account past claims experience, changes in characteristics of covered employees and dependents since the most recent time period covered by claims data, and other board-approved factors; and
7. the availability of a standard benefits package that cannot be any less comprehensive than the model benefits packages established by the act (see § 12).

§ 11 — INFORMATION CLEARINGHOUSE

Under the act, the board must recommend the establishment of an independent information clearinghouse to provide employers, individual consumers, and the general public with information about the care covered by the Sustinet Plan and private health plans. The Office of the Healthcare Advocate (OHA) is responsible for establishing the clearinghouse and contracting with an independent research organization to operate it. The clearinghouse must develop data specifications that show comprehensive information about quality of care, health outcomes for particular health conditions, access to care, patient satisfaction, adequacy of provider networks, and other performance and value information. OHA must develop the specifications in consultation with the board and private insurers.

The board must recommend that the Sustinet Plan and health insurers must submit data to the clearinghouse, the latter as a licensing condition. A self-insured group plan may provide data voluntarily, and dissemination of any information it provides is limited, based on negotiations between the clearinghouse and the plan.

The clearinghouse must not disseminate information that identifies individual patients or providers. To the extent possible, it must also adjust outcomes based on patient risk levels.

The clearinghouse must collect data based on each plan's provision of services over continuous 12-month periods. It must make all information public, subject to the limitations described above, no later than August 1, 2013, and update it annually each August.

#### § 12 — MODEL BENEFITS PACKAGES

The act requires OHA, within available appropriations, to develop model benefit packages that contribute the greatest possible amount of health benefit for enrollees, based on evolving medical and scientific evidence, for the premium cost typical of private ESI in the Northeast. By December 1, 2010, and then biennially, the office must report to the board on the updated model benefit packages.

After receiving these models, the board may modify the standard benefit package if it determines an adjustment would either yield better health outcomes for the same expenditure of funds or provide additional health benefits or reduced cost-sharing for particular groups that justify an increase in net costs. Any modification of the standard benefit package by the board must comply with statutory coverage mandates and utilization review requirements.

OHA must recommend guidelines for an incentive system to recognize employers who provide employees with benefits that are equivalent to or better than the model benefit packages.

By December 1, 2012, OHA must report on these guidelines and recommendations to the board; the governor; and the Public Health, Labor and Public Employees, and Appropriations committees.

#### § 13 — PUBLIC EDUCATION AND OUTREACH CAMPAIGNS

The act requires the board to develop recommendations for education and outreach campaigns to inform the public of Sustinet's availability and encourage enrollment. These campaigns must use community-based organizations to reach underserved populations. They must be based on evidence of the cost and effectiveness of similar efforts in this state and elsewhere. The board must continuously evaluate their effectiveness and change strategy as needed.

#### § 14 — IDENTIFICATION OF THE UNINSURED

The board, in collaboration with state and municipal agencies, must, within available appropriations, develop and implement recommendations to identify uninsured individuals. Such recommendations may include:

1. the Department of Revenue Services modifying state income tax forms to ask taxpayers to identify existing health coverage for each household member;
2. the Department of Labor modifying its unemployment insurance claims forms to ask about applicants' and their dependents' health insurance status; and

3. hospitals, community health centers, and other health care providers identifying uninsured individuals who seek health care and transmitting such information to the board.

#### § 15 — IDENTIFYING UNINSURED CHILDREN

The act directs the social services and education commissioners to consult with the board in their existing obligation to jointly establish procedures for sharing data from the National School Lunch Program to identify income-eligible children for enrollment in HUSKY A and B. And it permits these procedures to cover enrollment in the SustiNet Plan.

#### § 16 — OBESITY TASK FORCE

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

The task force includes the following members:

1. a representative of a consumer group with expertise in childhood and adult obesity, appointed by the House speaker;
2. two academic experts in childhood and adult obesity, one each appointed by the Senate president pro tempore and the governor;
3. two representatives of the business community with expertise in the subject, one each appointed by the House majority and minority leaders; and
4. two health care practitioners with expertise on the topic, one each appointed by the Senate majority and minority leaders.

The legislative appointees may be members of the General Assembly.

The commissioners of public health, social services, and economic and community development, and a representative of the SustiNet board are ex-officio, non-voting members. Appointments must be made within 30 days after the act's passage. Vacancies are filled by the appointing authority. The members appointed by the House speaker and the Senate president pro tempore serve as chairpersons. The first meeting must be held within 30 days after the act's passage. The Public Health Committee staff serves as the task force's administrative staff.

By July 1, 2010, the task force must report to the Public Health, Human Services, and Appropriations committees and the SustiNet board. The task force terminates when the report is submitted or January 1, 2011, whichever is later.

#### § 17 — TOBACCO USE TASK FORCE

The act establishes a task force to study tobacco use by children and adults. It must examine evidence-based strategies for preventing and reducing tobacco use and develop a comprehensive plan to reduce tobacco use. Its members are as follows:

1. a representative of a consumer group with expertise in tobacco use by children and adults, appointed by the House speaker;
2. two academic experts in the field, one each appointed by the Senate president pro tempore and the governor;
3. two representatives of the business community with expertise on the topic, one each appointed by the House majority and minority leaders; and
4. two health care practitioners with expertise in the field, one each appointed by the Senate majority and minority leaders.

These task force members may be legislators, except for the governor's appointee.

The commissioners of public health, social services, and economic and community development, and a representative of the Sustinet board are ex-officio, non-voting members. Appointments must be made, vacancies filled, and meetings held as described for the obesity task force. The chairpersons are the members appointed by the House speaker and the Senate president pro tempore.

By July 1, 2010, the task force must report to the Public Health, Human Services, and Appropriations committees. It terminates when it submits the report or January 1, 2011, whichever is later. The Public Health Committee staff serves as administrative staff.

#### § 18 — HEALTH CARE WORKFORCE TASK FORCE

The act establishes a task force to study the state's health care workforce. It must develop a comprehensive plan for preventing and remedying statewide, regional, and local shortages of necessary medical personnel. Its members are as follows:

1. a representative of a consumer group with expertise in health care, appointed by the House speaker;
2. one academic expert on the health care workforce, appointed by the Senate president pro tempore;
3. one academic expert in health care, appointed by the governor;
4. two representatives of the business community with expertise in health care, one each appointed by the House majority and minority leaders; and
5. two health care practitioners, one each appointed by the Senate majority and minority leaders.

The commissioners of public health, social services, and economic and community development, the president of UConn, the chancellors of the Connecticut State University System and the regional Community-Technical Colleges, and a representative of the Sustinet board are ex-officio, non-voting members. Members, except for the governor's appointee, can be legislators. Appointments must be made, vacancies filled, and meetings held as described above for the previous two task forces. The chairpersons are the members appointed by the House speaker and the Senate president pro tempore.

The Public Health Committee staff serves as administrative staff for the task force. The task force must report by July 1, 2010 to the Public Health, Human Services, and Appropriations committees. The task force terminates as described above.

Tracking: JK: SS: JL: ts