Agency Legislative Proposal – 2025 Session
Document Name: OHS – Certificate of Need

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Legislative Liaison	Cindy Dubuque-Gallo
Division Requesting This Proposal	Health Systems Planning
Drafter(s)	Cindy Dubuque-Gallo/Boyd Jackson

Title of Proposal	AAC Revisions to the Certificate of Need Program
Statutory Reference, if any	19a-639 et seq, 19a-638, 19a-630, 4-166
Brief Summary and Statement of Purpose	To clarify and update certain Certificate of Need (CON) provisions for the purpose of enhancing administration of the program for applicants and the agency
How does this proposal relate to the agency's mission?	Clarifying certain ambiguities in the CON program will make the process more user friendly while maintaining the integrity of the program. The Certificate of Need program is a tool to ensure appropriate health care systems planning for the State of Connecticut. These updates and clarifications to the CON statutes ensure that applications will be processed more smoothly and will reduce ambiguity or confusion.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1 (19a-643, applies to entire Chapter 368z Health Systems Planning Unit) allows for OHS to utilize policies and procedures in the CON statute while regulations are being promulgated.

Section 2 (19a-630) updates definition of termination of services

Section 3 (19a-638) adds proton radiotherapy machine to CON requirement

Section 4 (19a-639) Clarifies that a CON decision makers may consider any preliminary CMIR report, the applicants' response to the preliminary report and the CMIR Final Report in connection with decision maker's review of the CON criteria.

Section 5 (19-639a of the 2024 supplement) authorizes OHS to create an expedited CON review process

Section 6 (19a-639f) increases the amount allotted for a Cost and Market Impact Review from $200,000 to $300,000

BACKGROUND

Origin of Proposal [ ] New Proposal [x] Resubmission

This bill contains a subset of elements from last session, including from , HB 5316 (OHS's bill), SB 9 (OTG's bill), and SB 440 (PH Committee's bill) that touched on various aspects proposed in this bill.

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	In 2025, OHS anticipates the opening of CT's first Proton Beam Therapy facility, meaning that this will no longer be a "technology not in use in the state." Therefore an update to the CON statute is needed. The cost of conducting a Cost and Market Impact Review has not kept up with changing vendor requirements and has limited OHS's ability to find appropriate resources for the CMIR.
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	MA Title II, Chapter 6D, Section 13 has a CMIR process triggered if their Commission finds that the "material change is likely to have a significant impact" on the ability to meet the "health care cost growth benchmark". The CMIR report then goes to the Attorney General. California Code, Health and Safety Code - HSC § 127501 and HSC § 127507.2 require the CA Office of Health Care Affordability to review and evaluate consolidation, market power and other market failures through CMIRs.
Have certain constituencies called for this proposal?	Members of the Public Health Committee and the Hospital Association have supported streamlining the CON process.

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

[x] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT

Include the section number(s) responsible for the fiscal impact and the anticipated impact

[x] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN

If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[x] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Sec. 1. Subsection (b) of Section 19a-643 of the general statutes is repealed and the following is substituted in lieu thereof (*effective October 1, 2025)*

(b) The Office of Health Strategy may adopt such regulations, in accordance with the provisions of chapter 54, as are necessary to implement this chapter. The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner holds a public hearing at least thirty days prior to implementing such policies and procedures and publishes notice of intention to adopt the regulations on the Office of Health Strategy's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 2. Subsection (15) of Section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(15) "Termination of services" means the cessation of any services for (A) a [period] combined total of greater than one hundred eighty days within any two-year period, or (B) a period of at least thirty consecutive days.

Sec. 3. Subdivision (11) of subsection (a) of Section 19a-638 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(11) The acquisition of a proton radiotherapy machine or nonhospital based linear [accelerators] accelerator, except a certificate of need issued by the unit shall not be required where such machine or accelerator is a replacement for [an] a machine or accelerator that was previously acquired through certificate of need approval or a certificate of need determination;

Sec. 4. (NEW) Add subsection (6) to Subdivision (d) of Section 19a-639 of the general statutes (*Effective July 1, 2024*):

(d)(6) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, as amended by this act, that involves the transfer of ownership of a hospital and that is subject to a cost and market impact review, the unit shall be permitted to consider the preliminary report, response to the preliminary report, final report and any written comments from the parties regarding the reports issued or submitted as part of the review.

Sec. 5. (NEW) Add subsection (i) to Section 19a-639a of the general statutes (*Effective July 1, 2024*):

(i) (1) Notwithstanding the provisions of this section, the unit may develop and implement an expedited certificate of need review process for (A) certificate of need applications for (i) a service, facility or equipment identified as having a significant unmet need in the geographic region of the applicant in the most recently published final version of the state-wide health care facilities and services plan required under section 19a-634, (ii) the acquisition of a computed tomography scanner or magnetic resonance imaging scanner, and (B) any other categories of certificate of need application under subsection 19a-638(a) that the unit may designate as eligible to request expedited review, provided that the applicant under such category, pursuant to subdivision (2) of this subsection, (i) requests an expedited review of a certificate of need application, and (ii) clearly demonstrates that the subject of the application addresses a significant unmet need in the service area of the applicant. The unit may issue a decision on any certificate of need application eligible for expedited review pursuant to the provisions of this subdivision not more than thirty days after the unit receives an applicant's complete certificate of need application.

(2) An applicant for a certificate of need under a category designated as eligible to request expedited review may request, in a form and manner prescribed by the commissioner of the Office of Health Strategy, an expedited review of a certificate of need application pursuant to subparagraph (B) of subdivision (1) of this subsection. Such request shall include, but need not be limited to, (A) a description of the target population to be served by the subject of the certificate of need application, (B) a clear demonstration of a significant unmet need for the subject of the certificate of need application in the geographic region of the applicant based on patient demographics, diagnoses, utilization or other recent data, and (C) a description of the

availability of the subject of the certificate of need application in the primary service area of the applicant. The unit shall determine whether an applicant who requests an expedited review pursuant to the provisions of this subdivision is eligible for such expedited review not more than thirty days after the date that the unit receives the applicant's request.

(3) Notwithstanding the provisions of this section, an expedited certificate of need review process established pursuant to the provisions of this subsection shall (A) allow the unit to resolve an expedited certificate of need application by (i) agreed settlement with the applicant, (ii) making a determination approving the expedited certificate of need application with or without conditions, or (iii) requiring the applicant to submit a certificate of need application pursuant to the provisions of subsections (a) to (f), inclusive, of this section, and (B) not require a public hearing on an expedited certificate of need application.

(4) If the unit requires the applicant to submit a certificate of need application pursuant to clause (iii) of subparagraph (A) of subdivision (3) of this subsection, the unit shall (A) treat the expedited review application as a properly filed certificate of need application, (B) issue a request for additional information within thirty days of issuing notice of the requirement to submit a certificate of need application, and (C) follow the procedures as outlined in subdivisions (c) through (g) of this section.

(5) An expedited certificate of need review process established pursuant to the provisions of this subsection shall not be considered a contested case, as defined in section 4-166, as amended by this act. The unit's decision on any expedited certificate of need application submitted pursuant to the provisions of this subsection shall not be considered a final decision, as defined in section 4-166, as amended by this act.

Sec. 6. Subsection (j) of section 19a-639f of the general statutes are repealed and the following is substituted in lieu thereof *(Effective October 1, 2025)*

(j) The unit shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review, as described in this section. The unit shall submit bills for such services to the purchaser, as defined in subsection (d) of section 19a-639. Such purchaser shall pay such bills not later than thirty days after receipt. Such bills shall not exceed **[**two**]** three hundred thousand dollars per application. The provisions of chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19

shall not apply to any agreement executed pursuant to this subsection.

Document Name	OHS - Revisions to the Cost Growth Benchmark Program

Legislative Liaison	Cindy Dubuque-Gallo
Division Requesting This Proposal	OHS
Drafter(s)	Cindy Dubuque-Gallo/Boyd Jackson

Title of Proposal	AAC Revisions to the Cost Growth Benchmark Program
Statutory Reference, if any	Sec. 19a-754h through 19a-654k
Brief Summary and Statement of Purpose	To strengthen the Cost Growth Benchmark program to contain healthcare costs while maintaining access, quality and affordability of care to Connecticut's residents.
How does this proposal relate to the agency's mission?	OHS is committed to controlling the cost growth of health care while promoting equitable access to high quality healthcare. Evaluating performance improvement plans assists OHS in determining whether these are impactful policy tool for containing cost growth.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1. (19a-754h) Requires payers to ask an employer for the self-funded employee health plan to opt-in to provide data required for the benchmark. The payer may use a form established by OHS or a form accepted by the commissioner. The payer must report annually the number of employers who have opted in and out, a list of those who used opt-in but changed to opt-out, and a certification that the payer has made reasonable efforts to provide the opt-in form to employers.

Allows for OHS to level a civil penalty for failure of an insurer to seek approval from an employer to submit to OHS. Prevents insurers from charging employers extra money to submit data above and beyond the actual cost to the payer for submission

Section 2. (Section 19a-754j) Clarifies participation in the benchmark hearing and allows OHS to issue a subpoena for those who refuse to participate in the hearing as required by statute.

Requires OHS to conduct a one-time study to assess performance improvement plans as a tool to slow cost growth and evaluate what other states are doing and the outcomes.

Section 3. (19a-754k) Allows OHS to establish policies and procedures while regulations are promulgated

BACKGROUND

Origin of Proposal [X] New Proposal [x] Resubmission

Most of this is new, but the Performance Improvement Plan section was proposed in 2024 (HB 5054).

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	N/A
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	Utah has regulations that require insurers to provide an opt-in form to their self-funded clients, and the carriers must report annually the number of employers that opted in and out, identify those that opted in and certify responsible efforts to provide the form. Massachusetts has a performance improvement plan provision in its cost growth benchmark statue and includes a civil penalty as a last resort. See MA statute here: https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

	Massachusetts conducted a study of accountability mechanisms in 2022. They found that Expectations for payers, providers, and state agencies to control cost growth have become embedded in the cultural values of the state's health care system.
Have certain constituencies called for this proposal?	Yes, some legislators have called for accountability in the benchmark. This study will evaluate performance improvement plans as an accountability tool.

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

[x] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved** **[ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT

Include the section number(s) responsible for the fiscal impact and the anticipated impact

[x] Check here if this proposal does NOT have a fiscal impact

State	The budget impact may be positive for the state if an entity is required to pay a civil penalty.
Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN

If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

The CGB program is expected to have continued data submitted by employers via payers. This report will lead to policy recommendations that can inform the state's efforts to reduce cost growth.

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1. Section 19a-754h of the general statute is repealed and the following is substituted in lieu thereof *(effective October 1, 2025)*

(a) (1) Not later than August 15, 2022, and annually thereafter, each payer shall report to the commissioner, in a form and manner prescribed by the commissioner, for the preceding or prior years, if the commissioner so requests based on material changes to data previously submitted, aggregated data, including aggregated self-funded data as applicable, necessary for the commissioner to calculate total health care expenditures, primary care spending as a percentage of total medical expenses and net cost of private health insurance. Each payer shall also disclose, as requested by the commissioner, payer data required for adjusting total medical expense calculations to reflect changes in the patient population.

(NEW) *(Effective October 1, 2025)* (2) Any payer required to report data pursuant to subdivision (a)(1) of section 19a-754h, including aggregated self-funded employee health plan data as applicable, shall provide the employer for the self-funded employee health plan a copy of a form, in a manner specified by the commissioner, available on the departments website, to determine if the employer agrees to opt-in to submission of its self-funded employee health plan's data.

(3) A payer may use a form the insurer has developed for multi-state use instead of the form referenced in subdivision (a)(2) if the form is substantially similar and is approved in advance by the office.

(4) A payer shall provide the Opt-In Form within 15 days after claims administration services are retained and it is determined the employer meets the requirements of this section.

(5)(A) Except as provided in Subsection (4), an opt-in is effective for the reporting period in which it is signed and all future reporting periods.

(B) An employer may not opt-in for a partial reporting period.

(C) An employer that has opted-in may opt-out for subsequent reporting periods by notifying the payer in writing at least 30 days before the beginning of the next reporting period.

(6) For a self-funded employee health plan whose employer has made an affirmative election for the submission of data, the payer shall include the self-funded employee health plan data as part of the payer's data submission otherwise required by this statute.

(7) A payer shall file with the office, annually by January 31 of each year, the following for the prior calendar year:

(A) a list of self-funded employee health plans whose employer made an affirmative election for the submission of data;

(B) a list of employers who previously filed an opt-in request and have elected to opt-out for future reporting periods as provided under Subsection (5)(c);

(C) a certification from an officer of the payer that the payer has taken reasonable efforts to provide the form to all known required employers; and

(D) a list identifying the employers to whom the form was provided and their contact information.

(8) The Opt-In Form is for use only with self-funded employee health plans and does not affect the mandatory reporting otherwise required by this statute.

(9) Payers may not impose costs or fees on employers whose self-funded data is included in the reporting of aggregate data submitted beyond the actual cost to the payer for submission.

(NEW) (effective October 1, 2025) (g) Any payer that fails to provide an employer for a self-funded employee health plan a copy of the form under subdivision (2) of subsection (a) of this section, may be subject to civil penalties not to exceed ten dollars per covered individual enrolled in such self-funded plan to which the form was not provided.

Section 2. Subsection (a)(1) of Section 19a-754j of the general statute is repealed and the following is substituted in lieu thereof *(effective October 1, 2025)*

(a)(1) Not later than June 30, 2023, and annually thereafter, the commissioner shall hold an informational public hearing to compare the growth in total health care expenditures in the performance year to the health care cost growth benchmark established pursuant to section 19a-

754g for such year. Such hearing shall involve an examination of:

(A) The report most recently prepared by the commissioner pursuant to subsection (b) of section 19a-754h;

(B) The expenditures of provider entities and payers, including, but not limited to, health care cost trends, primary care spending as a percentage of total medical expenses and the factors contributing to such costs and expenditures; and

(C) Any other matters that the commissioner, in the commissioner's discretion, deems relevant for the purposes of this section.

(2) The commissioner may require any payer or provider entity that, for the performance year, is found to be a significant contributor to health care cost growth in the state or has failed to meet the primary care spending target, to participate in such hearing in a form and manner specified by the commissioner. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the commissioner and provide additional information on actions taken to reduce such payer's or entity's contribution to future state-wide health care costs and expenditures or to increase such payer's or provider entity's primary care spending as a percentage of total medical expenses.

(3) The commissioner may require that any other entity that is found to be a significant contributor to health care cost growth in this state during the performance year participate in such hearing in a form and manner specified by the commissioner. Any other entity that is required to participate in such hearing shall provide written and oral testimony, as requested by the commissioner, on issues identified by the commissioner and provide additional information on actions taken to reduce such other entity's contribution to future state-wide health care costs. If such other entity is a drug manufacturer, and the commissioner requires that such drug manufacturer participate in such hearing with respect to a specific drug or class of drugs, such hearing may, to the extent possible, include representatives from at least one brand-name manufacturer, one generic manufacturer and one innovator company that is less than ten years old.

(*NEW*) (4) If any entity refuses to participate in the hearing as required under subdivisions (2) or (3) of this subsection, the commissioner or commissioner's agent may issue subpoenas to such entity to require the attendance of witnesses or the production of records, correspondence, documents or other evidence in connection with the hearing.

(*NEW*) (5) *(Effective from passage)* Not later than January 1, 2026, the Office of Health Strategy shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance regarding an analysis of healthcare benchmark performance improvement plans, including, but not limited to, the use of performance improvement plans in other states as a tool to slow healthcare cost growth, the processes for instituting a performance improvement plan, the types of performance improvement plans other states have implemented, any achieved cost savings, and the effectiveness or limitations of such plans. Such report shall provide recommendations (1) on whether performance improvement plans should be implemented in Connecticut and if so, how they should be structured, (2) on how to measure the effectiveness of any performance improvement plans, and (3) any other recommendations the commissioner believes will contribute to slowing healthcare spending in Connecticut.

Section 3. Section 19a-754k of the general statute is repealed and the following is substituted in lieu thereof *(effective October 1, 2025)*

The Commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of section 19a-754a and sections 19a-754f to 19a-754j, inclusive. The commissioner may implement policies and procedures necessary to administer the provisions of section 19a-754a and sections 19a-754f to 19a-754j, inclusive, while in the process of adopting such policies and procedures in regulation form, provided the commissioner publishes notice of intention to adopt the regulations on the office's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Agency Legislative Proposal – 2025 Session
Document Name: Health Care Cabinet

Document Name	OHS-Health Care Cabinet

Legislative Liaison	Cindy Dubuque-Gallo
Division Requesting This Proposal	
Drafter	Cindy Dubuque-Gallo

Title of Proposal	AAC Technical Revisions to the Health Care Cabinet
Statutory Reference, if any	Sec. 19a-725
Brief Summary and Statement of Purpose	To update the cabinet membership to reflect the dissolution of SustiNet and the non-profit liaison Cabinet positions and remove reference to the Affordable Care Act.
How does this proposal relate to the agency's mission?	This proposal clarifies the membership of the Governor's Health Care Cabinet.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1: Outlines the allocation of the members previously appointed via SustiNet. Reallocates the non-profit liaison to the Governor to a member that represents nonprofits. Removes SustiNet language. Adds the Behavioral Health Advocate to the Cabinet. Section 2: Removes ACA language.

BACKGROUND

Origin of Proposal [x] New Proposal [ ] Resubmission

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	No
Has this proposal or a similar proposal been implemented in other states? If	No

yes, to what result?	
Have certain constituencies called for this proposal?	No

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

[x] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT

Include the section number(s) responsible for the fiscal impact and the anticipated impact

[x] Check here if this proposal does NOT have a fiscal impact

State	

Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN

If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[] Check here if this proposal does NOT lead to any measurable outcomes

It ensures that there is representation carved out for the non-profit sector.

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Sec. 19a-725. Health Care Cabinet: Membership; terms; duties. (a) There is established within the Office of Health Strategy, established under section 19a-754a, the Health Care Cabinet for the purpose of advising the Governor on the matters set forth in subsection (c) of this section.

Section 1: (b) (1) The Health Care Cabinet shall consist of the following members who shall be appointed on or before August 1, 2011: (A) [Five] Seven appointed by the Governor, two of whom may represent the health care industry and shall serve for terms of four years, one of whom shall represent community health centers and shall serve for a term of three years, one of whom shall represent insurance producers and shall serve for a term of three years, one representative from the Nonprofit Alliance for a term of three years and [one] two of whom shall be an at-large appointment and shall serve for a term of three years; (B) [one] two appointed by the president pro tempore of the Senate, one who shall be an oral health specialist engaged in active practice and one who shall be an at-large appointment and shall serve for a term of four years; (C) one appointed by the majority leader of the Senate, who shall represent labor and shall serve for a term of three years; (D) one appointed by the minority leader of the Senate, who shall be an advanced practice registered nurse engaged in active practice and shall serve for a term of two years; (E) [one] two appointed by the speaker of the House of Representatives, one who shall be a consumer advocate and one who shall be an at-large appointment and shall serve for a term of four years; (F) one appointed by the majority leader of the House of Representatives, who shall be a primary care physician engaged in active practice and shall serve for a term of four years; (G) one appointed by the minority leader of the House of Representatives, who shall represent the health information technology industry and shall serve for a term of three years; (H) two appointed by the Commissioner of Health Strategy; [five appointed jointly by the chairpersons of the SustiNet Health Partnership board of directors, one of whom shall represent faith communities, one of whom shall represent small businesses, one of whom shall represent the home health care industry, one of whom shall represent hospitals, and one of whom shall be an at-large appointment, all of whom shall serve for terms of five years]; (I) the Commissioner of Health Strategy, or the commissioner's designee; (J) the Secretary of the Office of Policy and Management, or the secretary's designee; the Comptroller, or the Comptroller's designee; the chief executive officer of the Connecticut Health Insurance Exchange, or said officer's designee; the Commissioners of Social Services and Public Health, or their designees; [and] the Healthcare

Advocate, or the Healthcare Advocate's designee, and the Behavioral Health Advocate, or the Behavioral Health Advocate's designee; all of whom shall serve as ex-officio voting members; and (K) the Commissioners of Children and Families, Developmental Services and Mental Health and Addiction Services, and the Insurance Commissioner, or their designees, [and the nonprofit liaison to the Governor, or the nonprofit liaison's designee], all of whom shall serve as ex-officio nonvoting members.

(2) Following the expiration of initial cabinet member terms, subsequent cabinet terms shall be for four years, commencing on August first of the year of the appointment. If an appointing authority fails to make an initial appointment to the cabinet or an appointment to fill a cabinet vacancy within ninety days of the date of such vacancy, the appointed cabinet members shall, by majority vote, make such appointment to the cabinet.

[(3) Upon the expiration of the initial terms of the five cabinet members appointed by SustiNet Health Partnership board of directors, five successor cabinet members shall be appointed as follows: (A) One appointed by the Governor; (B) one appointed by the president pro tempore of the Senate; (C) one appointed by the speaker of the House of Representatives; and (D) two appointed by majority vote of the appointed board members. Successor board members appointed pursuant to this subdivision shall be at-large appointments.]

(4) The Commissioner of Health Strategy, or the commissioner's designee, shall serve as the chairperson of the Health Care Cabinet.

Section 2. (c) The Health Care Cabinet shall advise the Governor regarding the development of an integrated health care system for Connecticut and shall:

(1) Evaluate the means of ensuring an adequate health care workforce in the state;

[(2) Jointly evaluate, with the chief executive officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;]

[(3)] (2) Identify short and long-range opportunities, issues and gaps created by the enactment of federal health care reform;

[(4)] (3) Review the effectiveness of delivery system reforms and other efforts to control health care costs, including, but not limited to, reforms and efforts implemented by state agencies; and

[(5)] (4) Advise the Governor on matters relating to: (A) The design, implementation, actionable objectives and evaluation of state and federal health care policies, priorities and objectives relating to the state's efforts to improve access to health care, (B) the quality of such care and the affordability and sustainability of the state's health care system, and (C) total state-wide health care spending, including methods to collect, analyze and report health care spending data.

(d) The Health Care Cabinet may convene working groups, which include volunteer health care experts, to make recommendations concerning the development and implementation of service delivery and health care provider payment reforms, including multipayer initiatives, medical homes, electronic health records and evidenced-based health care quality improvement.

(e) The Office of Health Strategy shall provide support staff to the Health Care Cabinet.