January Session, 2021

Proposed Substitute Bill No. 1090

LCO No. **6303**

AN ACT ESTABLISHING A COMMISSION TO STUDY A HUSKY FOR ALL SINGLE PAYER, UNIVERSAL HEALTH CARE PROGRAM.

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

Section 1. (*Effective July 1, 2021*) (a) As used in this section, "HUSKY for All Single Payer, Universal Health Care Program" means a single payer, universal health care program that: (1) Eliminates duplicative health insurance programs and resulting duplicative costs to the extent permissible under state and federal law; (2) consolidates oversight, payment and risk under one public or quasi-public entity; (3) eliminates coverage limits and cost sharing requirements, including, but not limited to, (A) deductibles, (B) copayments, and (C) coinsurance; (4) incorporates prescription drug price controls; and (5) establishes budgets and payment systems for hospitals for overnight care and a uniform fee schedule for health care providers not providing overnight care.

(b) There is established a commission to study establishing a HUSKY for All Single Payer, Universal Health Care Program in the state. The commission shall contract with an independent person or entity for an economic analysis of establishing such program provided such person or entity has completed not less than two such economic analyses of establishing a single payer, universal health care program on the state

or federal level.

(c) The commission shall be composed of:

(1) The executive director of the Office of Health Strategy, established pursuant to section 19a-754a of the general statutes, or the executive director's designee;

(2) The chief executive officer of the Connecticut Health Insurance Exchange, established pursuant to section 38a-1081 of the general statutes, or the chief executive officer's designee;

(3) The chairperson of the Council on Medical Assistance Program Oversight, established pursuant to section 17b-28 of the general statutes, or the chairperson's designee;

(4) The Healthcare Advocate, appointed pursuant to section 38a-1042 of the general statutes, or the Healthcare Advocate's designee;

(5) The chairpersons of the Behavioral Health Partnership Oversight Council, established pursuant to section 17a-22j of the general statutes, or their designees;

(6) The chairpersons of the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance, labor and public health, or their designees;

(7) At least six health care consumers appointed by the chairpersons of the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance, labor and public health, including, but not limited to, persons who have (A) collected unemployment within the past two years, (B) been uninsured for at least three months within the past two years, (C) obtained insurance through the Consolidated Omnibus Budget Reconciliation Act, or COBRA, due to circumstances including a voluntary or involuntary job loss within the past two years, (D) filed an individual income tax return itemizing medical expenses in the past five years, (E)

ever been ineligible to buy health insurance through the Connecticut Health Insurance Exchange, or (F) been uninsured and lack legal immigration status.

(8) The Insurance Commissioner and the Commissioner of Social Services, or their designees;

(9) The chief executive officer of the Connecticut Hospital Association, or the chief executive officer's designee;

(10) The president of the Connecticut State Medical Society, or the president's designee;

(11) Two providers of medical services under the medical assistance program and two persons who receive such services under the program, appointed by the chairperson of the Council on Medical Assistance Program Oversight;

(12) One representative each from Health Equity Solutions and United States of Care, appointed by the executive director of the Office of Health Strategy;

(13) Two representatives of the private health insurance industry, appointed by the executive director of the Office of Health Strategy in consultation with the Connecticut Association of Health Plans;

(14) Two representatives of labor unions representing employees who work in health care fields and one representative each from the Service Employees International Union and United Electrical Radio and Machine Workers of America, Local 222, appointed by the executive director of the Office of Health Strategy;

(15) Two persons from academia with expertise in economics or health insurance, or both, appointed by the executive director of the Office of Health Strategy, provided such persons shall not be among the independent persons contracting with the commission to produce an economic analysis of establishing a HUSKY for All Single Payer,

Universal Health Care Program;

(16) One representative from a community health center appointed by the executive director of the Office of Health Strategy;

(17) One representative from HealthCare Now appointed by the executive director of the Office of Health Strategy;

(18) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee; and

(19) Two representatives of non-profit organizations that provide direct legal representation to low-income Medicaid enrollees.

(d) The commission shall meet not later than thirty days after the effective date of this section. The executive director of the Office of Health Strategy, or the executive director's designee, shall serve as a chairperson of the commission and a second chairperson shall be chosen by the commission from among the members of the commission. The joint committee on legislative management shall provide administrative support to the commission. Any vacancies shall be filled by the executive director of the Office of Health Strategy or the appointing authority. If an appointing authority does not fill a vacancy within thirty days, the executive director of the Office of Health Strategy shall fill the vacancy.

(e) The commission shall study:

(1) Current health care spending, including, but not limited to: (A) State costs for the medical assistance program, (B) state costs for the Connecticut Health Insurance Exchange, (C) average individual consumer monthly health care costs for (i) participation in medical assistance programs requiring cost sharing by a participant, (ii) premiums and out-of-pocket costs for participants in the Connecticut Health Insurance Exchange, (iii) premiums and out-of-pocket costs for private health insurance plans, and (iv) premiums and out-of-pocket

costs for Medicare supplement plans, Medicare health maintenance organization plans and Medicare drug plans, (D) the costs for municipalities for both employees and retirees, and (E) the costs for small businesses and independent contractors.

(2) Sources of current health care financing, including, but not limited to: (A) Federal cost sharing for the medical assistance program, (B) employer and employee costs for private health insurance, (C) federal cost sharing for the Medicare program, and (D) participant cost sharing under the medical assistance program or the Medicare program.

(3) A financing methodology for a HUSKY for All Single Payer, Universal Health Care Program, including, but not limited to, whether such program should be financed, in part, through taxation on employers and employees.

(4) An economic analysis of establishing a HUSKY for All Single Payer, Universal Health Care Program, including, but not limited to, a comparison of: (A) State costs for the medical assistance program and oversight by the Insurance Department of private health care insurance and state costs under a HUSKY for All Single Payer, Universal Health Care Program, (B) consumer costs for private health care insurance and consumer costs under a HUSKY for All Single Payer, Universal Health Care Program, including any costs if the program is covered in part by taxation of a consumer, (C) employer and employee costs for private health care insurance and employer and employee costs if a HUSKY for All Single Payer, Universal Health Care Program is covered in part by taxation of an employer and an employee, and (D) participant cost sharing for medical assistance programs or Medicare and costs for such consumers under a HUSKY for All Single Payer, Universal Health Care Program.

(5) Provider payment rates under the medical assistance program, Medicare program and the private health insurance market and recommendations for provider payment rates under a HUSKY for All Single Payer, Universal Health Care Program.

(6) The number of residents uninsured or underinsured under the current health care coverage programs and the number of persons estimated to be uninsured or underinsured under a HUSKY for All Single Payer, Universal Health Care Program.

(7) What entity, or entities, should oversee a HUSKY for All Single Payer, Universal Health Care Program.

(8) A timeline for adoption of a HUSKY for All Single Payer, Universal Health Care Program, including, but not limited to, (A) implementing any financing methodology to fund such program, (B) eliminating the oversight of any agencies or offices currently overseeing health care coverage, and (C) creation of new oversight entities.

(9) The impact of a single payer, universal health care system on the labor market, including, but not limited to, (A) the ability of employees to move from job to job without the consideration of employer-sponsored health care benefits, and (B) the impact on current employees of the private, for-profit health insurance industry transitioning to new employment under a HUSKY for All Single Payer, Universal Health Care Program.

(10) The impact of a HUSKY for All Single Payer, Universal Health Care Program on achieving racial equity in access to quality, affordable health care, including, but not limited to, analyses of the program's potential impact on (A) disparities in insurance coverage by race and ethnicity, and (B) barriers for people of color to (i) health insurance enrollment, and (ii) utilization of health insurance.

(11) The impact of a HUSKY for All Single Payer, Universal Health Care Program on existing Medicaid enrollees.

(12) Best practices from efforts in other states and jurisdictions to promote health care affordability and universal health insurance coverage.

(f) Not later than January 1, 2022, the commission shall report, in

accordance with the provisions of section 11-4a of the general statutes, on the results of its study to the Office of Health Strategy and the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance, labor, public health and finance, revenue and bonding. The commission shall dissolve on the date such report is submitted, or on January 1, 2022, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2021*	New section