HB2436

LRB10011085MJP21342b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB2436

by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

New Act

Creates the Illinois Medicare for All Health Care Act. Provides that all individuals residing in the State are covered under the Illinois Health Services Program for health insurance. Sets forth the health coverage benefits that participants are entitled to under the Program. Sets forth the qualification requirements for participating health providers. Sets forth standards for provider reimbursement. Provides that it is unlawful for private health insurers to sell health insurance coverage that duplicates the coverage of the Program. Provides that investor-ownership of health delivery facilities is unlawful. Provides that the State shall establish the Illinois Health Services Trust to provide financing for the Program. Sets forth the requirements for claims billing under the Program. Provides that the Program shall include funding for long-term care services and mental health services. Provides that the Program shall establish a single prescription drug formulary and list of approved durable medical goods and supplies. Creates the Pharmaceutical and Durable Medical Goods Committee to negotiate the prices of pharmaceuticals and durable medical goods with suppliers or manufacturers on an open bid competitive basis. Sets forth provisions concerning patients' rights. Provides that the employees of the Program shall be compensated in accordance with the current pay scale for State employees and as deemed professionally appropriate by the General Assembly. Effective January 1, 2018.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Illinois Medicare for All Health Care Act.

Section 5. Purposes. It is the purpose of this Act to provide universal access to health care for all individuals within the State, to promote and improve the health of all its citizens, to stress the importance of good public health through treatment and prevention of diseases, and to contain costs to make the delivery of this care affordable. Should legislation of this kind be enacted on a federal level, it is the intent of this Act to become a part of a nationwide system.

Section 10. Definitions. In this Act:

"Board" means the Illinois Health Services Governing Board.

"Program" means the Illinois Health Services Program.

Section 15. Eligibility; registration. All individuals residing in this State are covered under the Illinois Health Services Program for health insurance and shall receive a card with a unique number in the mail. An individual's social

security number shall not be used for purposes of registration under this Section. Individuals and families shall receive an Illinois Health Services Insurance Card in the mail after filling out a Program application form at a health care provider. Such application form shall be no more than 2 pages long. Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to receive an Illinois Health Services Insurance Card and have payment made for such benefits.

Section 20. Benefits and portability.

(a) The health coverage benefits under this Act cover all medically necessary services, including:

(1) primary care and prevention;

(2) specialty care (other than what is deemed elective cosmetic);

(3) inpatient care;

(4) outpatient care;

(5) emergency care;

(6) prescription drugs;

(7) durable medical equipment;

(8) long-term care;

(9) mental health services;

(10) the full scope of dental services (other than elective cosmetic dentistry);

(11) substance abuse treatment services;

(12) chiropractic services; and

(13) basic vision care and vision correction.

(b) Health coverage benefits under this Act are available through any licensed health care provider anywhere in the State that is legally qualified to provide such benefits and for emergency care anywhere in the United States.

(c) No deductibles, copayments, coinsurance, or other cost sharing shall be imposed with respect to covered benefits except for those goods or services that exceed basic covered benefits, as defined by the Board.

Section 25. Qualification of participating providers.

(a) Health care delivery facilities must meet regional and State quality and licensing guidelines as a condition of participation under the Program, including guidelines regarding safe staffing and quality of care.

(b) A participating health care provider must be licensed by the State. No health care provider whose license is under suspension or has been revoked may participate in the Program

(c) Only non-profit health maintenance organizations that actually deliver care in their own facilities and directly employ clinicians may participate in the Program.

(d) Patients shall have free choice of participating eligible providers, hospitals, and inpatient care facilities.

Section 30. Provider reimbursement.

(a) The Program shall pay all health care providers according to the following standards:

(1) Physicians and other practitioners can choose to be paid fee-for-service, salaried by institutions receiving global budgets, or salaried by group practices or HMOs receiving capitation payments. Investor-owned HMOs and group practices shall be converted to not-for-profit status. Only institutions that deliver care shall be eligible for Program payments.

(2) The Program shall pay each hospital and providing institution a monthly lump sum (global budget) to cover all operating expenses. The hospital and Program shall negotiate the amount of this payment annually based on past budgets, clinical performance, projected changes in demand for services and input costs, and proposed new programs. Hospitals shall not bill patients for services covered by the Program, and cannot use any of their operating budgets for expansion, profit, excessive executive income, marketing, or major capital purchases or leases.

(3) The Program budget shall fund major capital expenditures, including the construction of new health facilities and the purchase of expensive equipment. The regional health planning districts shall allocate these capital funds and oversee capital projects funded from private donations.

(b) The Program shall reimburse physicians choosing to be paid fee-for-service according to a fee schedule negotiated between physician representatives and the Program on at least an annual basis.

(c) Hospitals, nursing homes, community health centers, non-profit staff model HMOs, and home health care agencies shall receive a global budget to cover operating expenses, negotiated annually with the Program based on past expenditures, past budgets, clinical performance, projected changes in demand for services and input costs, and proposed new programs. Expansions and other substantive capital investments shall be funded separately.

(d) All covered prescription drugs and durable medical supplies shall be paid for according to a fee schedule negotiated between manufacturers and the Program on at least an annual basis. Price reductions shall be achieved by bulk purchasing whenever possible. Where therapeutically equivalent drugs are available, the formulary shall specify the use of the lowest-cost medication, with exceptions available in the case of medical necessity.

Section 35. Prohibition against duplicating coverage; investor-ownership of health delivery facilities.

(a) It is unlawful for a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act. Nothing in this Act shall be construed

as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act.

(b) Investor-ownership of health delivery facilities, including hospitals, health maintenance organizations, nursing homes, and clinics, is unlawful. Investor-owners of health delivery facilities at the time of the effective date of this Act shall be compensated for the loss of their facilities, but not for loss of business opportunities or for administrative capacity not used by the Program.

Section 40. Illinois Health Services Trust.

(a) The State shall establish the Illinois Health Services Trust (IHST), the sole purpose of which shall be to provide the financing reserve for the purposes outlined in this Act. Specifically, the IHST shall provide all of the following:

(1) The funds for the general operating budget of the Program.

(2) Reimbursement for those benefits outlined in Section 20 of this Act.

(3) Public health services.

(4) Capital expenditures for construction or renovation of health care facilities or major equipment purchases deemed necessary throughout the State and approved by the Board.

(5) Re-education and job placement of persons who have lost their jobs as a result of this transition, limited to

the first 5 years.

(b) The General Assembly or the Governor may provide funds to the IHST, but may not remove or borrow funds from the IHST.

(c) The IHST shall be administered by the Board, under the oversight of the General Assembly.

(d) Funding of the IHST shall include, but is not limited to, all of the following:

(1) Funds appropriated as outlined by the General Assembly on a yearly basis.

(2) A progressive set of graduated income contributions: 20% paid by individuals, 20% paid by a business, and 60% paid by the government.

(3) All federal moneys that are designated for health care, including, but not limited to, all moneys designated for Medicaid. The Secretary shall be authorized to negotiate with the federal government for funding of Medicare recipients.

(4) Grants and contributions, both public and private.

(5) Any other tax revenues designated by the General Assembly.

(6) Any other funds specifically ear-marked for health care or health care education, such as settlements from litigation.

(e) The total overhead and administrative portion of the Program budget may not exceed 12% of the total operating budget of the Program for the first 2 years that the Program is in

operation; 8% for the following 2 years; and 5% for each year thereafter.

(f) The Program may be divided into regional districts for the purposes of local administration and oversight of programs that are specific to each region's needs.

(g) Claims billing from all providers must be submitted electronically and in compliance with current State and federal privacy laws within 5 years after the effective date of this Act. Electronic claims and billing must be uniform across the State. The Board shall create and implement a statewide uniform system of electronic medical records that is in compliance with current State and federal privacy laws within 7 years after the effective date of this Act. Payments to providers must be made in a timely fashion as outlined under current State and federal law. Providers who accept payment from the Program for services rendered may not bill any patient for covered services. Providers may elect either to participate fully, or not at all, in the Program.

Section 45. Long-term care payment. The Board shall establish funding for long-term care services, including in-home, nursing home, and community-based care. A local public agency shall be established in each community to determine eligibility and coordinate home and nursing home long-term care. This agency may contract with long-term care providers for the full range of needed long-term care services.

Section 50. Mental health services. The Program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions. The Program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, including institutional care.

Section 55. Payment for prescription medications, medical supplies, and medically necessary assistive equipment.

(a) The Program shall establish a single prescription drug formulary and list of approved durable medical goods and supplies. The Board shall, by itself or by a committee of health professionals and related individuals appointed by the Board and called the Pharmaceutical and Durable Medical Goods Committee, meet on a quarterly basis to discuss, reverse, add to, or remove items from the formulary according to sound medical practice.

(b) The Pharmaceutical and Durable Medical Goods Committee shall negotiate the prices of pharmaceuticals and durable medical goods with suppliers or manufacturers on an open bid competitive basis. Prices shall be reviewed, negotiated, or re-negotiated on no less than an annual basis. The Pharmaceutical and Durable Medical Goods Committee shall

establish a process of open forum to the public for the purposes of grievance and petition from suppliers, provider groups, and the public regarding the formulary no less than 2 times a year.

(c) All pharmacy and durable medical goods vendors must be licensed to distribute medical goods through the regulations outlined by the Board.

(d) All decisions and determinations of the Pharmacy and Durable Medical Goods Committee must be presented to and approved by the Board on an annual basis.

Section 60. Illinois Health Services Governing Board.

(a) The Program shall be administered by an independent agency known as the Illinois Health Services Governing Board. The Board will consist of a Commissioner, a Chief Medical Officer, and public State board members. The Board is responsible for administration of the Program, including:

(1) implementation of eligibility standards and Program enrollment;

(2) adoption of the benefits package;

(3) establishing formulas for setting health expenditure budgets;

(4) administration of global budgets, capital expenditure budgets, and prompt reimbursement of providers;

(5) negotiations of service fee schedules and prices

for prescription drugs and durable medical supplies;

(6) recommending evidenced-based changes to benefits; and

(7) quality and planning functions including criteria for capital expansion and infrastructure development, measurement and evaluation of health quality indicators, and the establishment of regions for long-term care integration.

(b) At least one-third of the members of the Board, including all committees dedicated to benefits design, health planning, quality, and long-term care, shall be consumer representatives.

Section 65. Patients' rights. The Program shall protect the rights and privacy of the patients that it serves in accordance with all current State and federal statutes. With the development of the electronic medical records, patients shall be afforded the right and option of keeping any portion of their medical records separate from the electronic medical records. Patients have the right to access their medical records upon demand.

Section 70. Compensation. The Commissioner, the Chief Medical Officer, public State board members, and subsequent employees of the Program shall be compensated in accordance with the current pay scale for State employees and as deemed

professionally appropriate by the General Assembly and reviewed in accordance with all other State employees.

Section 99. Effective date. This Act takes effect January 1, 2018.