



## 102ND GENERAL ASSEMBLY

### State of Illinois

2021 and 2022

HB0062

Introduced 1/14/2021, by Rep. Mary E. Flowers

#### SYNOPSIS AS INTRODUCED:

New Act

Creates the Health Care for All Illinois Act. Provides that all individuals residing in this State are covered under the Illinois Health Services Program for health insurance. Sets forth requirements and qualifications of participating health care providers. Sets forth the specific 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. Requires the State to establish the Illinois Health Services Trust to provide financing for the program. Sets forth the specific requirements for claims billed under the program. Provides that the program shall include funding for long-term care services and mental health services. 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. Provides that patients in the program shall have the same rights and privacy as they are entitled to under current State and federal law. Provides that the Commissioner, the Chief Medical Officer, the public State board members, and 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 July 1, 2021.

LRB102 03822 CPF 13836 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning health.

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

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

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

14 Section 10. Definitions. In this Act:

15 "Board" means the Illinois Health Services Governing  
16 Board.

17 "Program" means the Illinois Health Services Program.

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

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

11 Section 20. Benefits and portability.

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

- 14 (1) primary care and prevention;
- 15 (2) specialty care (other than what is deemed elective  
16 cosmetic);
- 17 (3) inpatient care;
- 18 (4) outpatient care;
- 19 (5) emergency care;
- 20 (6) prescription drugs;
- 21 (7) durable medical equipment;
- 22 (8) long-term care;
- 23 (9) mental health services;
- 24 (10) the full scope of dental services (other than  
25 elective cosmetic dentistry);

- 1           (11) substance abuse treatment services;  
2           (12) chiropractic services; and  
3           (13) basic vision care and vision correction.

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

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

12           Section 25. Qualification of participating providers.

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

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

20           (c) Only nonprofit health maintenance organizations that  
21 actually deliver care in their own facilities and directly  
22 employ clinicians may participate in the program.

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

1 Section 30. Provider reimbursement.

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

4 (1) Physicians and other practitioners can choose to  
5 be paid fee-for-service, salaried by institutions  
6 receiving global budgets, or salaried by group practices  
7 or health maintenance organizations receiving capitation  
8 payments. Investor-owned health maintenance organizations  
9 and group practices shall be converted to not-for-profit  
10 status. Only institutions that deliver care shall be  
11 eligible for program payments.

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

23 (3) The program budget will fund major capital  
24 expenditures, including the construction of new health  
25 facilities and the purchase of expensive equipment. The  
26 regional health planning districts shall allocate these

1 capital funds and oversee capital projects funded from  
2 private donations.

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

7 (c) Hospitals, nursing homes, community health centers,  
8 nonprofit staff model health maintenance organizations, and  
9 home health care agencies will receive a global budget to  
10 cover operating expenses, negotiated annually with the program  
11 based on past expenditures, past budgets, clinical  
12 performance, projected changes in demand for services and  
13 input costs, and proposed new programs. Expansions and other  
14 substantive capital investments will be funded separately.

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

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

25 (a) It is unlawful for a private health insurer to sell

1 health insurance coverage that duplicates the benefits  
2 provided under this Act. Nothing in this Act shall be  
3 construed as prohibiting the sale of health insurance coverage  
4 for any additional benefits not covered by this Act.

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

12 Section 40. Illinois Health Services Trust.

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

17 (1) The funds for the general operating budget of the  
18 program.

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

21 (3) Public health services.

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

1           (5) Re-education and job placement of persons who have  
2           lost their jobs as a result of this transition, limited to  
3           the first 5 years.

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

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

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

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

12           (2) A progressive set of graduated income  
13           contributions; 20% paid by individuals, 20% paid by  
14           businesses, and 60% paid by the government.

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

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

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

23           (6) Any other funds specifically earmarked for health  
24           care or health care education, such as settlements from  
25           litigation.

26           (e) The total overhead and administrative portion of the



1 program budget may not exceed 12% of the total operating  
2 budget of the program for the first 2 years that the program is  
3 in operation; 8% for the following 2 years; and 5% for each  
4 year thereafter.

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

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

21 Section 45. Long-term care payment. The Board shall  
22 establish funding for long-term care services, including  
23 in-home, nursing home, and community-based care. A local  
24 public agency shall be established in each community to  
25 determine eligibility and coordinate home and nursing home

1 long-term care. This agency may contract with long-term care  
2 providers for the full range of needed long-term care  
3 services.

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

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

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

22 (b) The Pharmaceutical and Durable Medical Goods Committee  
23 shall negotiate the prices of pharmaceuticals and durable  
24 medical goods with suppliers or manufacturers on an open bid

1 competitive basis. Prices shall be reviewed, negotiated, or  
2 renegotiated on no less than an annual basis. The  
3 Pharmaceutical and Durable Medical Goods Committee shall  
4 establish a process of open forum to the public for the  
5 purposes of grievance and petition from suppliers, provider  
6 groups, and the public regarding the formulary no less than 2  
7 times a year.

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

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

14 Section 60. Illinois Health Services Governing Board.

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

20 (1) implementation of eligibility standards and  
21 program enrollment;

22 (2) adoption of the benefits package;

23 (3) establishing formulas for setting health  
24 expenditure budgets;

25 (4) administration of global budgets, capital

1 expenditure budgets, and prompt reimbursement of  
2 providers;

3 (5) negotiations of service fee schedules and prices  
4 for prescription drugs and durable medical supplies;

5 (6) recommending evidence-based changes to benefits;  
6 and

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

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

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

24 Section 70. Compensation. The Commissioner, the Chief

1 Medical Officer, public State board members, and employees of  
2 the program shall be compensated in accordance with the  
3 current pay scale for State employees and as deemed  
4 professionally appropriate by the General Assembly and  
5 reviewed in accordance with all other State employees.

6 Section 99. Effective date. This Act takes effect July 1,  
7 2021.