



Health Care Availability and Access Committee

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1 AMENDMENT TO HOUSE BILL 311

2 AMENDMENT NO. _____. Amend House Bill 311 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be cited as the
5 Health 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

1 Board.

2 "Program" means the Illinois Health Services Program.

3 Section 15. Eligibility; registration. All individuals
4 residing in this State are covered under the Illinois Health
5 Services Program for health insurance and shall receive a card
6 with a unique number in the mail. An individual's social
7 security number shall not be used for purposes of registration
8 under this Section. Individuals and families shall receive an
9 Illinois Health Services Insurance Card in the mail after
10 filling out a Program application form at a health care
11 provider. Such application form shall be no more than 2 pages
12 long. Individuals who present themselves for covered services
13 from a participating provider shall be presumed to be eligible
14 for benefits under this Act, but shall complete an application
15 for benefits in order to receive an Illinois Health Services
16 Insurance Card and have payment made for such benefits.

17 Section 20. Benefits and portability.

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

20 (1) primary care and prevention;

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

23 (3) inpatient care;

24 (4) outpatient care;

1 (5) emergency care;

2 (6) prescription drugs;

3 (7) durable medical equipment;

4 (8) long-term care;

5 (9) mental health services;

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

8 (11) substance abuse treatment services;

9 (12) chiropractic services; and

10 (13) basic vision care and vision correction.

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

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

19 Section 25. Qualification of participating providers.

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

24 (b) A participating health care provider must be licensed
25 by the State. No health care provider whose license is under

1 suspension or has been revoked may participate in the Program

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

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

7 Section 30. Provider reimbursement.

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

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

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

1 marketing, or major capital purchases or leases.

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

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

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

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

1 of medical necessity.

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

4 (a) It is unlawful for a private health insurer to sell
5 health insurance coverage that duplicates the benefits
6 provided under this Act. Nothing in this Act shall be construed
7 as prohibiting the sale of health insurance coverage for any
8 additional benefits not covered by this Act.

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

16 Section 40. Illinois Health Services Trust.

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

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

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

1 (3) Public health services.

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

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

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

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

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

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

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

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

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

26 (5) Any other tax revenues designated by the General

1 Assembly.

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

5 (e) The total overhead and administrative portion of the
6 Program budget may not exceed 12% of the total operating budget
7 of the Program for the first 2 years that the Program is in
8 operation; 8% for the following 2 years; and 5% for each year
9 thereafter.

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

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

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

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

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

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

1 medical practice.

2 (b) The Pharmaceutical and Durable Medical Goods Committee
3 shall negotiate the prices of pharmaceuticals and durable
4 medical goods with suppliers or manufacturers on an open bid
5 competitive basis. Prices shall be reviewed, negotiated, or
6 re-negotiated on no less than an annual basis. The
7 Pharmaceutical and Durable Medical Goods Committee shall
8 establish a process of open forum to the public for the
9 purposes of grievance and petition from suppliers, provider
10 groups, and the public regarding the formulary no less than 2
11 times a year.

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

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

18 Section 60. Illinois Health Services Governing Board.

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

24 (1) implementation of eligibility standards and
25 Program enrollment;

- 1 (2) adoption of the benefits package;
- 2 (3) establishing formulas for setting health
3 expenditure budgets;
- 4 (4) administration of global budgets, capital
5 expenditure budgets, and prompt reimbursement of
6 providers;
- 7 (5) negotiations of service fee schedules and prices
8 for prescription drugs and durable medical supplies;
- 9 (6) recommending evidenced-based changes to benefits;
10 and
- 11 (7) quality and planning functions including criteria
12 for capital expansion and infrastructure development,
13 measurement and evaluation of health quality indicators,
14 and the establishment of regions for long-term care
15 integration.
- 16 (b) At least one-third of the members of the Board,
17 including all committees dedicated to benefits design, health
18 planning, quality, and long-term care, shall be consumer
19 representatives.

20 Section 65. Patients rights. The Program shall protect the
21 rights and privacy of the patients that it serves in accordance
22 with all current State and federal statutes. With the
23 development of the electronic medical records, patients shall
24 be afforded the right and option of keeping any portion of
25 their medical records separate from the electronic medical

1 records. Patients have the right to access their medical
2 records upon demand.

3 Section 70. Compensation. The Commissioner, the Chief
4 Medical Officer, public State board members, and subsequent
5 employees of the Program shall be compensated in accordance
6 with the current pay scale for State employees and as deemed
7 professionally appropriate by the General Assembly and
8 reviewed in accordance with all other State employees.

9 Section 99. Effective date. This Act takes effect July 1,
10 2008.".