



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB0207

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, 2019.

LRB101 04728 CPF 49737 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 State
6 that is legally qualified to provide such benefits and for
7 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 be
5 paid fee-for-service, salaried by institutions receiving
6 global budgets, or salaried by group practices or health
7 maintenance organizations receiving capitation payments.
8 Investor-owned health maintenance organizations and group
9 practices shall be converted to not-for-profit status.
10 Only institutions that deliver care shall be eligible for
11 program payments.

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

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

1 private donations.

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

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

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

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

24 (a) It is unlawful for a private health insurer to sell
25 health insurance coverage that duplicates the benefits

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

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

11 Section 40. Illinois Health Services Trust.

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

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

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

20 (3) Public health services.

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

25 (5) Re-education and job placement of persons who have

1 lost their jobs as a result of this transition, limited to
2 the first 5 years.

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

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

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

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

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

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

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

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

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

25 (e) The total overhead and administrative portion of the
26 program budget may not exceed 12% of the total operating budget

1 of the program for the first 2 years that the program is in
2 operation; 8% for the following 2 years; and 5% for each year
3 thereafter.

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

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

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

1 for the full range of needed long-term care services.

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

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

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

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

1 Pharmaceutical and Durable Medical Goods Committee shall
2 establish a process of open forum to the public for the
3 purposes of grievance and petition from suppliers, provider
4 groups, and the public regarding the formulary no less than 2
5 times a year.

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

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

12 Section 60. Illinois Health Services Governing Board.

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

18 (1) implementation of eligibility standards and
19 program enrollment;

20 (2) adoption of the benefits package;

21 (3) establishing formulas for setting health
22 expenditure budgets;

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

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

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

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

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

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

22 Section 70. Compensation. The Commissioner, the Chief
23 Medical Officer, public State board members, and employees of
24 the program shall be compensated in accordance with the current

1 pay scale for State employees and as deemed professionally
2 appropriate by the General Assembly and reviewed in accordance
3 with all other State employees.

4 Section 99. Effective date. This Act takes effect July 1,
5 2019.