



## 101ST GENERAL ASSEMBLY

### State of Illinois

2019 and 2020

HB0008

Introduced 1/9/2019, 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, 2020.

LRB101 02882 SMS 47890 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  
5 Illinois Medicare for All Health Care 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 non-profit 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 HMOs  
7 receiving capitation payments. Investor-owned HMOs and  
8 group practices shall be converted to not-for-profit  
9 status. Only institutions that deliver care shall be  
10 eligible for Program payments.

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

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

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

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

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

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

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

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

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

10 Section 40. Illinois Health Services Trust.

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

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

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

19 (3) Public health services.

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

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

1 the first 5 years.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

11 Section 60. Illinois Health Services Governing Board.

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

17 (1) implementation of eligibility standards and  
18 Program enrollment;

19 (2) adoption of the benefits package;

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

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

25 (5) negotiations of service fee schedules and prices

1 for prescription drugs and durable medical supplies;  
2 (6) recommending evidence-based changes to benefits;  
3 and  
4 (7) quality and planning functions including criteria  
5 for capital expansion and infrastructure development,  
6 measurement and evaluation of health quality indicators,  
7 and the establishment of regions for long-term care  
8 integration.  
9 (b) At least one-third of the members of the Board,  
10 including all committees dedicated to benefits design, health  
11 planning, quality, and long-term care, shall be consumer  
12 representatives.

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

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

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

3 Section 99. Effective date. This Act takes effect January  
4 1, 2020.