

## SPECIFICATIONS OF THE SINGLE-PAYER PROPOSAL FOR ILLINOIS

The single-payer proposal creates a single source of comprehensive health insurance for all Illinois residents. The program includes a comprehensive benefits package covering hospital care, physician services, and prescription drugs. It would also cover durable medical equipment, eyeglasses and rehabilitative services. People would have their choice of physicians, hospitals, and other caregivers.

The benefits package would, at a minimum, equal that received by Illinois legislators, state employees, and uniformed servicemen.

The program would place hospitals and other health facilities on annual budgets for operations and capital expenditures, thus eliminating the need for billing for hospital care. The majority of providers would be reimbursed on a fee-for-service basis unless they are salaried employees of a hospital. Health professionals would continue to operate their own practices and health facilities would remain independently owned.

We summarize the major components of the program created under the proposal in the following sections:

- Governance
- Eligibility
- Covered services
- Benefits Design
- Disposition of Medicaid
- Exclusion of Workers Compensation Medical Benefits
- Non-profit staff-model HMO coverage option
- Provider payments in first year
- Program Financing
- Health spending in future years
- (New) Special provisions for Quality Improvement
- (New) Special provisions for Long Term Care
- (New) Special provisions for Health Planning/Workforce Issues
- (New) Special provisions for Mental Health
- (New) Special provisions for Dental and Vision

A similar proposal is pending in the state of California (SB 840 is the current bill number, it was SB 921 last year). A fiscal analysis of SB 921 is included in the appendix to this submission, along with a slightly different single payer plan for California (prepared as part of the California “Health Care Options Project”) and fiscal analyses for single payer plans in several other states (Maine, Georgia, Massachusetts, and Vermont).

### A. Governance

We assume that an independent agency is established to administer the single-payer system for Illinois called the Illinois Health Care Agency (IHCA). The program would be directed by a Commissioner in conjunction with a public state board and Chief Medical Officer. The Commissioner would be responsible for administration of the program including:

- Implementing eligibility standards and program enrollment
- Adopting a benefits package
- Establish formulae for setting health expenditure budgets
- Administer the program including providing for the prompt payment of providers
- Negotiate prices for prescription drugs and durable medical equipment
- Recommending an evidence-based benefits package
- Other administrative functions
- Other quality and planning functions, including:
  - Establish criteria for capital expansions and infrastructure development
  - Measure and evaluate indicators of health care quality.
  - Establish regions for long-term care integration

Within the Office of the Attorney General:

An Inspector General for Health would have broad subpoena powers to investigate fraud in the program and to respond to consumer complaints.

(New) Consumer Participation:

At least one-third of the members of the public state board, including all committees dedicated to benefits design, health planning, quality, and long-term care, should be consumers. Hospitals and other facilities that receive global budgets must have at least one-third consumers on their governing boards. Long-term care public agencies receiving global budgets must have consumers on their Boards.

Thus, consumers shall participate in determination of benefit package in conjunction with providers and experts. Consumers also participate in allocation of budget and health planning, including capital funds for infrastructure expansion, purchase of major equipment, etc. Consumers help shape local long-term care arrangements.

Finally, free choice of provider allows patients to shape the system by choosing to receive their care from the most responsive, highest quality providers.

## B. Eligibility

All state residents would be covered for a standard benefits package after a 3-month waiting period. The waiting period is designed to avoid covering out-of-state residents with pre-existing conditions who might relocate to Illinois solely to take advantage of the

program. The three month residency requirement is assumed to be waived for the following:

- People relocating to Illinois to take a job
- People experiencing a change in family status due to divorce or death of a spouse
- For emergency services
- (New) For pregnant women

### C. Covered Services

The plan would cover the following services:

- Inpatient/outpatient health facility or clinic services
- Inpatient and outpatient professional provider services by licensed professionals
- Diagnostic imaging, laboratory services, and other diagnostic and evaluative services
- Rehabilitative care
- Emergency transportation and necessary transportation for health care services for disabled people
- Home and Community based care (for people with limitations in ADL) and the medical portion of nursing home and other institutional care
- Prescription drugs that are listed on the system formulary. Off-formulary prescription drugs may be included where special standards and criteria are met
- Mental Health Care
- Dental care
- Durable medical equipment including hearing aid

Services not covered by the program include:

- Non-prescription medications and non-durable medical supplies
- Health services determined to have no medical indication
- Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery
- Private rooms in inpatient facilities unless determined to be medically necessary by a qualified licensed health care provider in the system
- Room and board in long-term care (except for low-income).
- Services provided by unlicensed or unaccredited providers

### D. Benefits Design

For the first two years of the program, there would be no deductibles or co-payments under the program. However, the benefits package would be designed to increase emphasis on primary and preventive care as follows:

- Participants would be encouraged to select a primary care physician from one of the primary care specialties including internists, family physicians, pediatricians, family nurse practitioners and physician assistants practicing under supervision of a physician as required under the Illinois code. Women would have the option of selecting a gynecologist for primary care. Permanently disabled persons would have the option of choosing a specialist who knows their condition(s) well.
- (Modified) Patient visits to physician specialists without a referral by a primary care provider would be paid at the primary care rate, giving specialists an incentive to work collaboratively with primary care doctors (Referral is not required for each follow-up visit to a specialist.)

After two years, the commissioner is authorized to adjust deductibles and/or co-payments if necessary subject to the following restrictions:

- Co-payment amounts would be limited not to exceed \$250 per individual and \$500 per family per year
- Deductibles would be limited not to exceed \$250 per individual and \$500 per family per year
- No co-payments or deductibles will be established for preventive care

(New) For the purposes of economic modeling, the modest co-pays and deductibles that may be applied starting in the third year (as stated above) should be included in the modeling so that the AHCTF has a full assessment of the costs of the program.

The proposal would require the use of a prescription drug formulary based upon prices negotiated with pharmaceutical manufacturers. Under this system, specific drugs are selected for inclusion in the formulary for each type of medical therapy. Providers would not be permitted to prescribe off-formulary medications (usually higher cost) unless the formulary drug is ineffective or inappropriate (e.g., side-effects from formulary medication).

The proposal would also negotiate for discounts with manufacturers of durable medical equipment. Under this system, the state would contract with suppliers who offer the lowest price for their equipment. This means that the medical equipment offered by manufacturers and/or suppliers who do not bid the lowest price in the competitive bidding process generally would not be covered under the program. This design would enable the state to negotiate deep discounts for durable medical equipment.

#### E. Disposition of Medicaid

Funding for Medicaid would be redirected into the state fund that would provide benefits to all Illinoisans. No current beneficiary of Medicaid shall lose coverage of any service.

These services include:

- Nursing home care including room and board for low income people who have or would qualify for Medicaid.
- Certain non-prescription medications
- Non-durable medical equipment
- Non-emergency transportation
- EPSDT services for children now covered under Medicaid, including:
  - Hearing
  - Medically necessary orthodontia
  - Non-rehabilitative therapies including
    - Speech therapy
    - Occupational therapy
    - Physical therapy

#### F. Exclusion of Workers Compensation Medical Benefits

We assume that the medical component of the workers compensation program would be unaffected and remain separate from the Act. Thus we assume no change in workers compensation medical coverage and benefits. The medical component of workers compensation could be folded into the program in the future.

#### G. Non-profit staff-model HMO Coverage Option

- A “Kaiser-like” option for Illinois is maintained. HMOs that employ physicians on salary, own clinics, and deliver care on a private, non-profit basis receive a global budget. People who choose this option are generally assumed to be required to remain in the plan for a year. However, there is a three month trial period in which patients may disenroll for any reason. They may also disenroll at any time if the health plan can not provide needed care.
- Global budgets with adjustment for the health of the enrollees to avoid overpayment or underpayment based on selective enrollment.

#### H. Provider Payments in First Year

Health spending for covered services under the program would be determined through a budgeting process designed to control the growth in health spending for Illinois. Spending in the first year of the program would be determined as follows:

- Hospitals and clinics would be given annual budgets that in the first year are equal to what total spending for hospital and clinic services would have been in that year under the current system. Separate budgets would be set for operations and capital expansion.

- Fee-for-service (FFS) payment rates for other providers would be set so that on average, payment rates under the program in the first year are equal to overall average payment rates across all payers in today's system (i.e., private payers, Medicare and Medicaid) for each individual unit of service. These include payments from private payers, Medicare, and self-pay (includes prices for services purchased by the uninsured and prices paid by insured people for services that are not covered under their health plan).

The program would permit the Commissioner to adjust payments for certain types of providers or services to reflect desired changes in the allocation of health resources. For example, payments for primary care services could be increased to reflect a desired increase in emphasis on primary and preventive care. However changes in reimbursement levels for other services would be adjusted so that total spending does not exceed the aggregate levels of spending determined above.

Hospital budgets and aggregate FFS provider payments would be adjusted to reflect the following:

- Increased utilization for newly insured
- Increased utilization due to elimination of co-payments
- Changes in spending due to the primary care model
- Reductions in bad debt and charity care costs for providers
- Provider administrative savings

## I. Financing

The program would be financed with funds that would have been used for public programs under current law and certain dedicated taxes created under the program. Federal Medicaid, Medicare, and other necessary waivers would be obtained.

- Funding for current federal and state health insurance programs would be recovered including:
  - Medicaid (state and federal shares)
  - State Children's Health Insurance Program (SCHIP)
  - Medicare (including contributions by the federal government to Part D)
  - IHS
  - VA and CHAMPUS
  - FEHBP
  - Categorical programs (e.g. Ryan White Care Act)
  - State health care safety net funds
  - County safety net funds to the extent not needed for safety net services

We assume that the amounts of state and county funding would be indexed by the allowable rate of growth in spending (i.e., GDP growth) as determined by the Commissioner through the budgeting process. Because health spending has been growing considerably faster than the rate of growth in state GDP, this would result in lower levels of health spending for state and county governments in future years than what they would face under current cost trends.

However, we assume that the amount of federal funding provided to the state in future years would be indexed to the average rate of growth in costs in these programs nationally. This is designed to assure that federal funding for the state is not reduced over-time. Thus, from the federal government's perspective, the program is designed to be budget-neutral.

Costs in excess of the amounts of spending collected from existing programs would be raised through new progressive dedicated taxes created to replace regressive insurance premiums and out-of-pocket payments eliminated under the program. These would be determined during the modeling process by the fiscal analyst, but might include:

- Payroll tax on employers and employees (e.g. ~ 7% and ~ 2%, respectively)
- Business tax on self-employed net-income (both parts of payroll tax)
- Non-wage/business tax: small ~ 2 percent (non-wage and investment income)
- Surcharge on Income: 2 percent of income above \$250,000 (all taxable income)

The business and payroll tax rates would be adjusted each year to the level required to pay for the program. The adjustment might include raising the floor and ceiling that the tax applies to (e.g. payroll tax floor \$7,000 and ceiling \$200,000).

## J. Health Spending in Future Years

The program would determine the increase in health spending permitted in each year. We assume that the program is required in legislation to constrain the rate of growth in health spending so it does not exceed the long-term rate of growth in gross domestic product (GDP) for Illinois. Budget levels would be set on the basis of the long-run projected rate of growth in GDP rather than actual GDP growth. This is necessary so that funding levels for the health care system do not fluctuate over time with short-term variations in state GDP growth.

Spending caps would be implemented through:

- Annual hospital and clinic budgets for operations
- Annual hospital and clinical capital expansion budgets
- Caps on the rate of growth in negotiated FFS provider payment rates

Spending levels for services would be adjusted to reflect the cost of prescription drugs and durable medical equipment (with bulk purchasing savings) so that aggregate spending under the program is within budgeted levels. For purposes of this analysis, we assumed that FFS payment rates also would be adjusted to reflect any increases in utilization of FFS services that occur during the year so that aggregate spending for these services does not exceed budgeted levels (without an adjustment for increased utilization, spending would increase above budgeted levels).

The system would include reports to providers on quality of care indicators and referral patterns for comparison purposes. Peer review also would be established to monitor referral patterns and quality of care indicators.

#### K. (New) Special provisions for Quality Improvement

The single payer proposal for Illinois would be guided by 10 key quality principles, particularly the principles of evidence-driven standards of care and continuous quality improvement (below).

- We propose providing all practitioners with standardized confidential electronic medical record software (such as VISTA) for no cost with electronic lab results, and prescribing. The resulting unified database will support clinical practice and create the information infrastructure needed to improve care overall.
  - i. Electronic medical records, electronic prescribing (based on a state formulary, adapted from the VA formulary) and lab reporting are critical to error reduction and patient safety.
  - ii. The VA has already developed the needed software for physician practices and provides a model for improving quality system-wide. Taking advantage of advances already developed in the public sector (including Medicare) will allow Illinois to become a leader in health care IT.
  - iii. The integrated database will facilitate more sophisticated outcomes research (on new processes of care, drugs, and procedures) as well as fraud detection. Some possible uses are: to identify physician outliers who order excess diagnostic tests or referrals; to identify unsafe drugs and safer alternatives, to identify underserved areas for mammograms or other preventive measures; and to determine outcomes and best practices for specialized services (e.g. dialysis).
  - iv. Permits evidence-based outcomes assessment and intervention at individual, physician, and community level. Improving individual providers' care can best be accomplished via supporting their ability to practice quality care coupled with pooled outcomes data and patient feedback.



- We propose that health planning should assess and direct resources – both monetary and the health (and public health) care workforce - as needed to improve quality. For example, capital investments (in clinics, emergency departments, etc), caregivers, and targeted public health interventions are needed in underserved areas. Increases are needed in the primary care workforce at all levels (nurses, physician assistants, primary care physicians, etc). There are more details Section L (below) but some are included here because health planning is so critical to improving quality.
  - i. Use regional health planning boards to determine distribution of funds for construction or renovation of health facilities and purchases of major medical equipment. Work in conjunction with public health department to also deploy targeted public health interventions (the unified database and epidemiological studies will be especially useful in this regard).
  - ii. Enlarge the primary care workforce by using Illinois’ hospitals’ share of Graduate Medical Education funds, as well as modest bonuses, enhanced fees, and non-monetary professional rewards (such as public recognition, leadership opportunities, etc) to attract more professionals into primary care training programs, primary care practices, and underserved areas.
  - iii. Special strategies to increase the diversity of the primary care workforce will need to be tested and implemented until there is minority representation in the workforce equal to the state’s population. “Raiding” the workforce of developing countries is not an acceptable strategy.
- We propose to regionalize specialized surgeries and tests. Currently, redundant surgical suites jeopardize quality when complicated surgeries like heart bypasses are performed too infrequently to maintain proficiency.
- In addition to facilitating improved quality, single payer reduces the cost of the current malpractice system. Timely care and continuity of caregivers fosters improved quality, so there is less malpractice. EHRs and electronic prescribing reduce errors. In addition, the proposal eliminates lawsuits for future medical expenses (the majority of cases), since future medical expenses are covered. Thus, defensive medicine and malpractice premiums will fall substantially (by 50 percent or more). Also, under single payer the focus in malpractice cases can broaden from “who will pay for mistakes” to “how can we learn from mistakes and prevent them,” which is critical to improving quality.

GUIDING QUALITY PRINCIPLES FOR THE SINGLE PAYER PROPOSAL:

1. There is a profound and inseparable relationship between access and quality: universal insurance coverage is a prerequisite for quality care.
  2. The best guarantor of universal high-quality care is a unified system that does not treat patients differently based on employment, financial status, or source of payment.
  3. Continuity of primary care is needed to overcome fragmentation and overspecialization among health care practitioners and institutions.
  4. A standardized confidential electronic medical record and resulting database are key to supporting clinical practice and creating the information infrastructure needed to improve care overall.
  5. Health care delivery must be guided by the precepts of CQI (continuous quality improvement).
  6. New forums for enhanced public accountability are needed to improve clinical quality, to address and prevent malpractice, and to engage practitioners in partnerships with their peers and patients to guide and evaluate care.
  7. Financial neutrality of medical decision making is essential to reconcile distorting influences of physician payment mechanisms with ubiquitous uncertainties in medicine.
  8. Emphasis should shift from micromanagement of providers' practices to macroallocation decisions. Public control over expenditures can improve quality by promoting regionalization, coordination, and prevention.
  9. Quality means prevention. Prevention means looking beyond medical treatment of sick individuals to community-based public health efforts to prevent disease, improve functioning and well-being, and reduce health disparities.
  10. Affordability is a quality issue. Effective cost control is needed to ensure availability of quality health care both to individuals and the nation.
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L. (New) Special provisions for Long Term Care

PNHP's proposal for Illinois long-term care reform is based on work by Dr. Christine Cassell, former Professor of Geriatrics at the U of C and current President of the American Board of Internal Medicine, and Charlene Harrington, RN, Ph.D., the nation's leading investigator into quality problems in nursing homes. Their proposal, "A National Long-term Care Program for the United States: A Caring Vision" appeared in the JAMA, December 4, 1991. Their recommendations are adapted for the state of Illinois.

We propose the incorporation of LTC into the publicly funded state health program. We borrow from the experience in the Canadian provinces of Manitoba and British Columbia, where LTC is part of the basic health care entitlement regardless of age or income. Case managers and specialists in needs assessment (largely non-physicians) evaluate the need for LTC and authorize payment for services.

#### Specific features and budgeting process

- Establish a state LTC Planning and Payment Board, and a local public agency in each community to determine eligibility and coordination of home and nursing home long term care.
- The local public agency will receive a global budget and contract with long term care providers for the full range of LTC services. Nursing homes, home care agencies, and other institutional providers will be paid a global budget to cover all operating costs and would not bill on a per-patient basis. Individual practitioners may continue to be paid on a fee-for-service basis or could receive salaries from institutional providers. Support for innovation, training of LTC personnel, and monitoring the quality of care will be greatly augmented, as a portion of the funds saved on administrative overhead are shifted into long-term care service provision (see below)
- Separate capital budgets allow for health planning that meets community needs.
- Expand social and community based services, and integrate them with institutional care. Logic dictates that the system emphasize social services, not just medical ones, with social service and nursing personnel rather than physicians often coordinating care
- The public program, with a single, uniform benefit package, would consolidate all current federal and state programs for LTC. At present, 80 federal programs finance LTC services, including Medicare, Medicaid, the Department of Veterans Affairs, and Older Americans Act.
- Coverage would extend to anyone, regardless of age or income, needing assistance with one or more activity of daily living (ADL) or instrumental activity of daily living (IADL). In the first 5 years, priority is given to patients needing assistance with three or more ADL or IADLs, and to those who can avoid institutional care with home and community-based care.
- Clerical and other administrative workers who lose their jobs as a result of the single payer will be given incentives to re-train and take employment in the expanded home and community-based health care sector which is currently understaffed. Training and in-service education of LTC professionals, paraprofessionals, and informal care givers should be expanded. Salaries, working conditions, and skill levels of workers in this area need to be upgraded.
- Removing financial barriers to LTC will increase demand for formal services. In the first year, allow for a 25 percent increase in home and community-based care (in addition to any savings from institutional care). The program is to be financed entirely by tax revenues, without premiums, deductibles, co-payments or coinsurance, with the exception of “room and board” payments by patients who are not low-income needing institutional care.

M. (New) Special provisions for Health Planning/Workforce Issues

The Illinois single payer will allow the state to do real health planning, directing resources to areas of unmet need in terms of both geography and specialty (e.g. public health, prevention, primary care, long-term care, and mental health and substance abuse, etc.). The goal of health planning is to assure that the most appropriate providers are delivering timely, high quality care, to all patients, and that public health interventions and new capital appropriations will maximally improve the health of state residents.

Some specific features:

- Improve and expand primary care, the most efficient setting for care delivery. Give modest financial incentives to providers to work in underserved areas, along with other professional rewards (recognition, leadership opportunities, etc). Similar incentives may be given to increase the diversity of the workforce.
- Shift graduate medical education funds to adjust mix of training programs to increase the diversity of health professionals and to train more primary care providers.
- Pay specialists at primary care rate if patient does not have a referral, giving specialists incentives to work collaboratively with primary care physicians.
- Distribute funding for construction or renovation of health facilities and for purchases of major equipment to underserved areas, reducing health disparities.
- Buy out investor owned, for profit delivery facilities (mostly nursing homes). Pay for the cost of the physical plant only, not the “brand name.” Finance the buy-back with 15-20 year bonds.
- Set and meet targets for decreasing health disparities, and increasing prevention, every year. Use the unified database to identify areas of need and assess progress.
- Create a long-term plan for educating and hiring the appropriate mix of health care professionals and allied health professionals that are needed in the state.

N. (New) Special provisions for Mental Health Coverage Parity

Millions of Illinois residents are uninsured and under-insured for mental illness/substance abuse. Many patients in need of hospital or residential care are unable to obtain inpatient services even if they have insurance. Breakthroughs in medications in recent years have made mental illness more treatable than ever but are unaffordable for many.

Very ill patients are often expected to juggle complicated medication routines with little support; in many cases severely mentally ill homeless patients are discharged to the streets. Jails have become the largest inpatient facilities for the treatment of the severely mentally ill. Suicidal patients are sometimes given a 1-800 number to call in lieu of prompt access to urgent care.

Health care is a right, and all residents of Illinois should have access to high-quality services for mental illness and substance abuse, with coverage on par with the coverage of medical or surgical care.

An overview of our proposal on mental health:

Mental health care and substance abuse treatment must be available to all, and the substandard care that is now the norm must be upgraded. Coverage should include the full range of effective treatments, including: outpatient psychotherapy and medication management; acute inpatient care; rehabilitation and occupational therapy; a range of substance abuse treatment options (including inpatient) and medications.

To the extent possible, patients should have their choice of physicians, other caregivers, and treatment settings, and new mental health facilities should be preferentially located in neighborhoods with the greatest needs. The delivery system should be entirely not-for-profit to prevent the continued diversion of resources to profits.

There should not be arbitrary caps on inpatient or outpatient care for the seriously mentally-ill. The mental health professions must give increased attention to the seriously mentally ill, and to substance abuse treatment. In addition, there is a particular need for more focus on illnesses in children.

Specific features:

- Payment for mental health care should be on the same terms as payments for other medical services; patients with serious mental illness (e.g. depression, bi-polar disorder, schizophrenia) should not be subject to higher co-pays or deductibles. Research shows that out-of-pocket charges have the impact of discouraging both necessary and unnecessary care and most negatively impact the poor.
- There are large unmet needs in mental health and substance abuse treatment in Illinois. Substantial new resources will be needed to upgrade mental health services. Statewide mental health surveys can be used to supplement the unified database to understand where the unmet needs are greatest.
- Some of the new resources needed in mental health care can be garnered by eliminating the for-profit managed mental health intermediaries (e.g. Magellan) that have come to dominate care in the past decade, and whose overhead and profits may consume 50% or more of the total money designated for mental health services.
- Additionally, resources should be diverted from the criminal justice system; excessive incarceration is, at present, the major response to serious mental illness and substance abuse.
- Grossly inflated medication prices should be cut through exerting the purchasing power of a single payer.
- As in all sectors of health care, spending and patterns of care should be audited to ensure that the most urgent needs are met first, and that ineffective, harmful, and cost-ineffective practices are eliminated.

- We advocate a mental health system based on compassion and science rather than on the dictates of the market.

O. (New) Special provisions for Dental and Vision

Dental benefits are included in the state single payer program, with the exception of purely cosmetic dentistry.

Vision screenings are covered, along with one pair of eyeglasses per year.